

Pediatric Physical & Occupational Therapy Services Pacific Northwest Pediatric Therapy

The Offices of Rosemary White, OTR/L & Associates

Main Office

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Check List for Completion of Intake Questionnaire Birth to 36 Months

- IMPORTANT:** Save the Word document "Intake Questionnaire" on your computer BEFORE you fill it out.
 - o Complete the Intake Questionnaire (Word Document) in as much detail as possible.
 - o Remember to save the completed questionnaire on your computer until we verify receipt at our office.
- Retain a copy of the completed intake questionnaire for your records.
- Return a printed copy of the completed questionnaire to:
 - **Seattle:** Pediatric PT & OT Services, 20310 19th Ave NE, Shoreline, WA 98155
 - o Fax: 206-367-9609
 - o Email: pedptot@comcast.net

FINANCIAL / BILLING INFORMATION

Date questionnaire completed: _____

CHILD'S NAME: _____ Male or Female: Date of Birth: Age:
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PARENT/GUARDIAN (Please underline one: Father / Mother / Guardian) NAME: _____ DOB: _____ Employer: Occupation: Work Phone: Cell Phone: Email: Home Address: City: State: Zip Code: Home Phone:

PARENT/GUARDIAN (Please underline one: Father / Mother / Guardian) NAME: _____ DOB: _____ Employer: Occupation:

Work Phone:
Cell Phone:
Email:
Home Address (If different from other parent or guardian):
City:
State:
Zip Code:
Home Phone:

CHILD RESIDES AT THE FOLLOWING ADDRESS (If different from above):

Home Address:
City:
State:
Zip Code:

HOW DID YOU LEARN ABOUT PEDIATRIC PHYSICAL AND OCCUPATIONAL THERAPY SERVICES?

Response:

WHO RECOMMENDED THAT YOU SEEK OUT THESE SERVICES FOR YOUR CHILD?

Response:

PRIMARY OR REFERRING DOCTOR:

Doctor's Address:
Phone:

DATE OF PRESCRIPTION OR REFERRAL FROM PHYSICIAN (Required to provide diagnosis for submitting claims to insurance):

DIAGNOSIS:

DATE OF ONSET:

INSURANCE COMPANY: _____

Claims Address:

Insurance Company Phone Number:

Insurance Company Fax Number:

Subscriber's Name:

Subscriber's Date of Birth:

Subscriber's Relationship to Child (i.e. Father or Mother):

ID Number (Please Include Alpha Characters):

Name of Insured Group or Employer:

Group or Plan Number:

Contact Person:

NOTE: we must have a signed "authorization for exchange of information" on file before we can release records or share information. Please complete the authorization form and include all names, addresses and phone numbers with whom you want us to share your child's information.

- Please list the names and addresses of whomever you would like to receive a copy of the initial Occupational Therapy Assessment written report. (These names must also be included on the signed "Authorization for Exchange of Information.")

INTAKE INFORMATION

Please put your answers in the area below the question – dedesignated for "Response" and feel free to write in bullet form.

Remember to include (in the final section under "Plan") the days of the week and the times of the day that are best for you and your child for regular weekly therapy sessions. This is very helpful information when scheduling Occupational Therapy sessions.

TELL ME ABOUT YOUR CHILD:

What brings you and your child joy when you interact with one another?

Response:

What kinds of things does your child enjoy?

Response:

What things about your child do you especially enjoy?

Response:

What are your child's gifts?

Response:

PERTINENT INFORMATION:

Home situation – Are parents married/divorced? Any siblings?

Response:

When did parents become concerned about behaviors?

Response:

PLEASE DESCRIBE THE MAJOR CONCERNS YOU HAVE AS TO WHY YOU ARE SEEKING OCCUPATIONAL THERAPY FOR YOUR CHILD:

What are the overall goals for your child receiving Occupational Therapy? (More detailed goals will be asked for at the end of the questionnaire.)

Response:

What are you most concerned about now?

Response:

IN ORDER TO MEET YOUR NEEDS PLEASE DESCRIBE YOUR UNDERSTANDING OF DIR/ FLOORTIME:

Below are the Functional Emotional Developmental Capacities that are addressed in interactions in DIR/Floortime

- Co-regulation and Shared attention
- Engagement
- Use of affect, gesture, vocalizations and /or words to show intentions and the ability to read the intentions of others in a back and forth interaction.
- The ability to stay in a long continuous flow of an interaction, a sense of self (power both physically and emotionally) and shared social problem solving.
- Representational play and symbolic play with peers.
- Building bridges between ideas and emotional thinking in play that has a logical flow with a beginning, middle and end.

For more detail on DIR/Floortime go to www.pedptot.com, www.profectum.org, www.icdl.com

Are you familiar with the DIR/Floortime model that is incorporated into our Occupational Therapy practice?

Response:

Are there aspects of the DIR/Floortime model, that are outlined above, you are wanting to be a focus in your child's Occupational Therapy treatment sessions?

Response:

IN ORDER TO MEET YOUR NEEDS AND THE NEEDS OF YOUR CHILD IT IS HELPFUL FOR ME TO BE AWARE OF ALL OTHER SERVICES YOUR CHILD IS RECEIVING AT THIS TIME -

Have you or are you receiving Occupational Therapy services previously? If so, where, from whom and how long?

Response:

Have you or are you receiving speech and language services? If so, where, from whom and how long?

Response:

Have you or are you receiving psychology or social work services to support you and your child? If so, where, from whom and how long?

Response:

Please list all other services being received either at school or privately and include the names of the providers and/or schools:

Response:

PERTINENT HISTORY:

IN ORDER TO UNDERSTAND YOUR CHILD AND HIS PRESENT ABILITIES IT IS HELPFUL FOR ME TO HAVE AN UNDERSTANDING OF EARLY HISTORY. IN ADDITION IF THERE ARE ANY SIGNIFICANT FAMILY HISTORY FACTORS THAT MAY PROVIDE ADDITIONAL INFORMATION IN HELPING ME UNDERSTAND YOU CHILD AND IN PROVIDING A MORE COMPREHENSIVE CONSULTATION, PLEASE COMPLETE:

Please describe your child's prenatal and birth history.

Response:

Please describe your child's early developmental history.

Response:

Please describe any significant family history.

Response:

FUNCTIONAL SKILLS:

Gross Motor:

Describe your child's gross motor skills (Can he/she roll, crawl, walk, climb on furniture.)

Response:

Fine Motor/Tool Use (utensils, pencils):

Does your child pick up and manipulate small objects.

Response:

Does your child hold a bottle, a sippy cup, hold a spoon or fork or utensil you use during daily activities.

Response:

How does your child grasp blocks, stuffed animals, or favorite small toys?

Response:

Dressing Skills:

Does your child assist with dressing?

Response:

If your child assists with dressing describe how. (e.g. Lifts arms for shirt, or sock, lifts legs during diaper changing)

Response:

Play Skills:

Describe the play activities that your child engages in.

Response:

How does your child play around his peers?

Response:

Does your child play by him/herself? For how long?

Response:

If your child plays by him/herself & has a problem making a toy work, or getting a toy, how does he/she get your attention?

Response:

Communication and Speech and Language:

Describe how you child communicates with you and familiar people in his life.

Response:

Do you have concerns about your child's ability to communicate and/or speech and language?

Response:

Does your child follow or seem to comprehend your gesture during and interaction?

Response:

Does your child follow or seem to comprehend verbal directions?

Response:

Describe your child's receptive language? For example, when you talk about a toy and describing it does he gaze at the parts that you are describing, or if you move and describe a part does he/she appear to follow the words and action? If you are stating that it is time to leave does he look in the direction of his coat or your car keys?

Response:

Does your child use gesture to communicate?

Response:

What is you child's expressive language like? For example, does he use gesture more than words, uses jargon with gestures, some single word that you and those familiar with him/her understand.

Response:

Does he/she stay in a back and forth flow of interaction (can be gestures, vocalizations, jargon, words) with you and familiar people?

Response:

Daycare/Childcare

Are you the primary caregiver for your child?

Response:

Who else looks after your child on a regular basis?

Response:

Does your child attend daycare/childcare? If so where and for how long during the week?

Response:

If in daycare/childcare does your child transition into and out with ease?

Response:

Are there any concerns with daycare/childcare?

Response:

RESPONSE TO SENSORY STIMULI:

We want to find out how your child responds to different types of sensory information in the environment.

Throughout our day-to-day functions we are constantly processing sensations from our own body and from our interaction with the environment and developing meaningful perceptions.

- Sensory input from the body and from the environment occurs simultaneously. For example, we are constantly hearing, seeing, and experiencing touch and movement all at the same time.
- Sensory systems communicate with one another and contribute each individual's perceptions. For example, when you hear a footstep behind you the speed of the sound and the volume will contribute to your visualizing if the footsteps are from an adult or a child, if they are walking or running.
- Sensations are connected with emotions and the affective tone that occurs with the sensory experience. For example, if a child sees a dog and those around them are smiling and bending down to pat the dog then the emotion and affective tones communicate to the child that touching and interacting with the dog will be a positive experience. However, if those around the child tense up and look fearful the emotion and affective tone will convey a negative perception.

The outcome of this is unique to each individual's experience & neurobiological profile.

The sense of **touch** has many important functions, including providing us with the ability to perceive and make meaning of the contact of our hands, and our body on the wide variety of objects we manipulate and explore. The sense of touch is referred to as "the body's ear." Touch perception enables us to know what an object is without looking (tactile discrimination) and identifying and respond to temperature and pain. Touch also plays a crucial role in the development of fine motor abilities and overall body awareness. In our interactions with others we touch and we are touched and this give meaning to the intent of others and supports social rhythms.

The sense or awareness of movement has many important functions. Our muscles are constantly firing (proprioception) sending information about the position of our body parts to one another, this communicates with our gravity related system (vestibular organs) enabling us to perceive and interpret position of our body as it relates to changes in head position and supports our awareness of where we are in space. This then communicates with our vision to automatically coordinate movements of one's eyes, head and body. Functionally the communication of the sense of movement, gravity awareness and vision is essential for the development of body awareness and body and space abilities and in perceiving and adapting movement of the body.

Vision consists of both the motor function of the eye as well as perception of visual information. Vision is closely connected to the sense of touch as well as the sense of the body in space and contributes to visual spatial perceptions.

The **auditory system** contributes to the ability to locate and discriminate sounds. It enables one to connect sounds to people and objects in the environment so that we can perceive and develop the ability to understand what a sound is related to and thus make meaning of a sound or sounds. The child's ability to respond to the spoken word, to understand and follow directions occurs as they connect what they hear with the actions and gestures of others indicating that audition is closely linked to vision, visual spatial and body awareness. As the child develops speech and language occurs as they pair what they hear with what they see, how they co-ordinate their oral muscles to produce words. Communication is more than words as it brings in speech and language with the ability to understand the words of others as well as maintain a physical presence with others and to have rhythm and timing of speech and actions that are adapted to those we are communicating with, hence there is a visual spatial and body aspect to communication.

Taste and smell are very basic senses that provide information about our environment. The emotional tone, such as the facial expression or the body posture of others, that occurs with these senses are crucial for one to develop accurate perceptions and as such these senses can soothe us, as well as protect us. These senses set the foundation of awareness and comfort with bodily functions such as eating, toileting and they also contribute to emotional connections with others.

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The sensory systems function in concert with one another and it is the synchrony of the sensory experiences with the emotional tone and the environment, including interactions with others, that gives meaning to events and experiences. Experiences are unique for each individual and so it is important for us to understand each child and how he/she is processing, perceiving and responding to sensory input from their own body and from the environment.

General State:

Can you describe your child's general state of awareness and response to the environment? Response:
When you review your child's day, how much is he/she awake/ asleep and for how long (daytime naps, night)? Response:
How much of your day is spent soothing your child? Response:
How does your child sooth him/herself? Response:

Touch Awareness Related to Function and Social Interactions:

Is your child comfortable with the feel of clothes such as the texture of fabrics, jeans, socks and shoes? Response:
Is your child comfortable with hair brushing, washing, cutting, nail cutting, teeth brushing, etc.? Response:
Does your child engage with you and in an age expected way assist with in hair brushing, washing, teeth brushing, etc.? Response:
Is your child comfortable when he/she is touched by others in during social interaction? For example, is your child comfortable when you interact to point out something, or when playing on the floor beside you or a sibling or another infant or toddler? Response:

Movement and Balance:

Is you child comfortable engaging in movement and/or movement related activities? For example, riding in a stroller, playing "piggy back", and roughhouse play. Please give some examples. Response:
Is your child comfortable being moved off balance? For example, in roughhouse play being tipped or rocked. Response:
Does your child enjoy movement activities? Response:

Does your child engage in movement activities to a greater degree than his peers? For example, does he /she frequently engage in rolling back and forth, rocking on all fours or rocking when standing.

Response:

Touch and Motor Awareness:

When manipulating objects, does your child tend to hold the object too tight or too loose?

Response:

When you assist your child with a physical task such as dressing or getting into the car, does your child assist with the movement?

Response:

Does your child anticipate when he/she is going to be picked up and appear to get his body ready for the movement? For example, for infants about 5 months and then older, when you reach out with your hands indicating you are going to pick him/her up does he/she start to prepare his/her body in anticipation of the movement and ready for the action?

Response:

If your child is mobile does he/she negotiate moving around the room, around furniture, around objects and other people successfully?

Response:

Awareness of Sound:

Does your child enjoy sounds that occur in the environment?

Response:

Does your child have accurate perceptions related to sounds? For example, when he/she hears a knock at the door, a truck backing up, a siren or a toilet flush does he/she have an understanding of the source of the sound?

Response:

Does your child enjoy making sounds? For example, makes loud sounds, sings to himself, hums.

Response:

Is your child comfortable with everyday household sounds, such as the sound of the refrigerator, the washing machine, the flushing of the toilet?

Response:

Is your child comfortable when there is a sound outside the room? For example, footsteps in the hall, a vacuum in another room or a mower outside, a plane flying overhead.

Response:

Visual Awareness:

Is your child comfortable in a busy visual environment? For example a busy playroom or the mall.

Response:

Is your child comfortable in sunlight?

Response:

Does your child flexibly shift his/her visual attention with others during social interaction?

Response:

Does your child like to hold an object, such as a small figurine, in their hand for long periods of time without using it for play?

Response:

Awareness of Taste and Smell:

What are your child's eating habits?

Response:

Is your child's diet limited due to texture?

Response:

Does your child exhibit any sensitivity to smells?

Response:

Is your child sensitive or allergic to any foods?

Response:

Internal Sensations:

How does your child communicate or what are the behaviors you recognize that indicate that your child is hungry, thirsty, tired?

Response:

Response to Pain and Temperature:

If your child gets hurt how does he respond to pain?

Response:

What do you have to do to comfort him when he is hurt?

Response:

If your child touches or puts something in his mouth that is hot, or he perceives it as "too hot", how does he respond?

Response:

If your child touches or puts something in his mouth that is cold, or he perceives it as "too cold", how does he respond?

Response:

TEMPERAMENT:

Every child is a unique individual with his/her own rhythms. It is helpful for me to learn about your child and his rhythms and responses in his everyday life both at home and in the community.

Need for Routine:

Does your child do better with a structured routine?

Response:

What happens if the routine is altered?

Response:

Sleep (settling, sleep, arising):

Does your child settle with ease to go to sleep in the evening?

Response:

Do you have a bedtime routine? Please describe the routine if you have one.

Response:

How long does it take for your child to go to sleep in the evenings?

Response:

Does your child wake up during the night? If yes, how do you put him/her back to sleep?

Response:

How does your child wake up in the mornings?

Response:

Community Settings:

Is your child comfortable in stores or malls, etc?

Response:

Does your child do well and tolerate the activity around him in these settings?

Response:

Does your child do well in restaurants when you wait to order and receive your food?

Response:

Does your child enjoy going to the park? If so what does he/she enjoy?

Response:

Attention Span:

Describe your child's attention span.

Response:

What does your child enjoy doing for long periods?

Response:

Transitions:

Does your child adapt well and with ease during transitions? For example, leaving the park, getting into the car to go to the store, packing away toys for dinner.

Response:

How do you prepare your child for transitions?

Response:

Trying Something New:

Is your child willing to try something new? For example trying a new food, wearing a new outfit, going to a new place.

Response:

Does your child enjoy trying something new? For example, he is eager to try a toy and will explore it with you.

Response:

Activity level:

Do you consider your child's activity level average compared to his peers? If no, please describe.

Response:

SOCIAL:

Family Members:

Can you describe how your child interacts with you, his/her parents?

Response:

Can you describe how your child interacts with his/ her siblings/extended family?

Response:

Peers:

Does your child enjoy social interaction and communicating with other children?

Response:

Does he/she maintain social interactions with other infants and children in a way that you expect for his/her age?

Response:

In our effort to provide the most effective therapy services please list what are the areas of function that you would like to see change over the course of therapy for your child. For example change in the areas of tolerating sensory input relative to daily activities, gross and fine motor skills, play skills and social interaction.

Response:

Or, let's pretend that therapy is over and you are deciding whether treatment was successful. What are 5 or so changes that would make you say "Yes, that was worth the time, money and effort we put into it?"

Response:

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PLAN:

Please provide your availability for therapy – days and times that work best or days and times that will not work for a weekly Occupational Therapy Appointment.

Please mark the location that is the most convenient site for weekly Occupational Therapy appointments.

- Main office north of Seattle in Shoreline, WA
- South Seattle office
- Portland, OR office

Please keep in mind that before and after school appointments are most often filled first and remain filled longest and there will be a longer waiting time for an appointment before or after school. To help schedule we ask that you please consider pulling your child out of school for therapy and let us know if there is a day of the week and the time of the day that would work best for him/her to leave school for therapy services. We suggest that you check with your child's teacher to see what he/she recommends if it is necessary to pull your child from school to receive therapy.

Flexibility in scheduling will increase the likelihood of having your child begin therapy more quickly. We always work hard to schedule therapy as soon as we can and to keep the waiting time as short as possible.

Please tell us when you are available – days of the week and times of the day that are best.

- **Clinic hours are 8 AM to 5 PM Monday through Friday.**

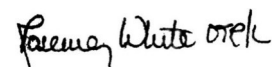
Response:

Please tell us if there are there any special instructions for evaluating/treating therapist?

Response:

Parents, thank you for providing this information, it will assist us in determining the most appropriate evaluation tools and treatment modalities and is valuable when establishing therapy goals and monitoring progress.

We will contact you to confirm receipt of your intake information and to discuss scheduling.



Rosemary White, OTR/L