

Child Intake Form

Date:

Name: Age: DOB:

Address:

Email:

Mom/Dad Cell:

Mother:

Father:

Siblings:

Referral: Previous Therapy:

Medical History:

Tonsils and Adenoids Removed:

Sleep Study:

Allergies:

Sensitivities:

Medications:

Vaccinations:

Surgeries:

Medical Conditions:

Birth History (Traumatic, Complications, C-Section, Forceps, Vacuum):

Your Story:

Proper Breast feeding Info (How long):

Bottle Fed (How long):

Pacifier Use (How long):

Sippy Cup (How long):

With or without a straw?

Age child began eating solid foods:

Childhood Trauma, Fall or Injuries:

Explain:

Nutritional Info:

Allergies:

Sensitivities:

Dietary Restrictions:

Breakfast:

Lunch:

Dinner:

Snacks:

Pouching of food or liquid when eating?

Messy:

Fast:

Food falls out:

Chews with mouth open:

Gas:

Stomach Ache:

Chokes:

Airway:

Mouth Breathing:

Nasal Breathing:

Combination of Mouth/Nose

Chest or Abdominal Breathing:

Combination of Chest/Abdominal Breathing:

Gags Easily:

Swallow Pills with Ease:

Sore Throats:

Asthma:

Colds/Sinus Infections:

Earaches:

Ringings:

Ear Wax:

Glasses or eyewear:

Headaches:

How Often:

Where:

Type:

Snoring:

How Often:

Clenching or Grinding at night:

Restless legs at night:

Nightmares/Night Terrors:

Bed Wetting:

How Many Times Do You Get Up to Use the Bathroom at Night:

Do You Wake Up Tired or Refreshed:

T.V or Digital Clock in bedroom:

Noxious/Bad Habits(Now or as a child)

Thumb/Finger Sucking:

How Long:

When:

Blanket/clothing:

How Long:

When:

Cheek/Tongue:

How Long:

When:

Nail Biting/Lip Licking:

How Long:

When:

Activities/Sports/Musical Instruments:

Type:

Injuries:

Challenges:

Has anyone ever told you that your child may be tongue-tied or have a tongue thrust?

Has your child ever had troubles with speech, or been in a speech therapy program?

Does your child exhibit ADD/ADHD symptoms, hyperactivity issues, behavioral issues or anxiety?

Did your child have any difficulties feeding as an infant?

Has your child experienced any breathing issues or difficulties? (chronic congestion, asthma, etc.)

Has your child had their tonsils removed, or have you been told the tonsils are enlarged?

Do you notice that your child occasionally has his/her mouth open at rest?

Do you notice that your child tends to breathe through his/her mouth more often than their nose?