Kidz on the Move Family
Intake & Developmental History Form

General Information

Child's Name: _____ Age: _____ Birth Date:_____

Home Address: _____
(Street) (City/Street/Zip)

Phone:(H) _____(C) _____(W) _____

Primary Phone: _____

Email Address: _____

Parents: _____ Marital Status: _____

Both parents have custody? Yes/No If no, who has primary custody? _____

Mother's Occupation: _____

Father's Occupation: _____

Name and ages of siblings: _____

Referred By: _____

Pediatrician's Name: _____

Insurance company (Name and Member ID#):_____

Medical Information

Has your child received any previous OT or PT services? Yes/No

If so, when and where? _____

Medical Diagnosis, if any: _____

ANY KNOWN ALLERGIES: _____

If so, does your child require an epi-pen? Yes/No

Has your child received a hearing/vision test? Yes/No Results: _____

Does your child wear glasses Yes/No

Has your child had any of the following? If yes, describe and give dates.

Childhood diseases or major illnesses: _____

Surgeries: _____

Hospitalizations: _____

Ear Infections: _____

Ear tubes: _____

Seizures: _____

Medications: _____

Pregnancy History
Any medications during pregnancy? Yes/No
List: _____
Any complications? _____

Birth History
Was your child:
Full Term? Yes/No Birthweight: _____
Premature? Yes/No Number of weeks: _____
C-Section delivery? Yes/No
Breastfed? Yes/No
Any difficulties with nursing, sucking or breathing? _____

Developmental Milestones: Please note approximate age your child attained the following:
Rolled: _____ Sat independently: _____Crawled:_____
Walked: _____
Toilet trained: _____
Babbled: _____ Said first words: _____Said 1-2 word phrases: _____

Family History
Please indicate any significant family history for the following:
Speech/Language: _____
Hearing: _____
Learning: _____
Emotional: _____
Physical: _____

Additional Comments:_____
_____
_____
_____
_____
_____
_____
_____