1751 Sarno Rd, Unit 5, Melbourne, FL 32935 P: 321-255-7779 F: 321-255-7774 W: www.7sensestherapy.com

7 SENSES THERAPY

Gaining Skills for Life!

Client Intake Form

Child's Name: _____DOB:_____ School:_____
Child Enjoys: _____ Diagnosis:_____

Mother/Guardian Name: _____ Date: _____
Profession_____Employer_____
Average Work Hours Wk: _____Average Time Spent Playing with Child Wk:_____
Favorite Activity with Your Child:_____
Single__ Married__

Father/Guardian Name:_____
Profession: _____Employer:_____
Average Work Hours Wk: _____Average Time Spent Playing with Child Wk:_____
Favorite Activity with Your Child:_____

Address: _____City_____Zip_____
Home Phone_____Work_____Cell_____
Email: _____

Have you seen an Occupational Therapist before? Yes___ No___ When_____
Whom may we thank for referring you to our office?_____

Physician/Pediatrician: _____
Physician Address: _____City_____ Zip_____
Physician Phone: _____

Pediatric Health History

1. Please describe any significant illnesses/difficulties/traumas during **your pregnancy** with this child: _____

_____

2. Please check off all that apply to the birth of this child: Home birth _____
Hospital birth _____ Length of labor _____ Epidural _____

Episiotomy _____ Other Medications used_____
Caesarean _____ Vaginal_____ Forceps_____ Vacuum_____
Manual assistance_____
3. Was your baby breastfed? _____ If yes, how long?_____
4. Has your child received vaccinations: YES/NO complete for their age _____ partial _____ no vaccinations _____
5. Any sleeping problems?_____
6. At what age did your child crawl? _____
7. At what age did your child walk? _____
8. Please describe any falls, stitches, fractures, car accidents, sports injuries or other traumas that your child has experienced since birth: Include ages/dates.

_____

_____

9. Please tell us about any health issues/chronic illnesses that your child has had since birth (include ages/dates):_____
10. Any known allergies including foods?

_____

11. Please list any medications that your child has or is currently taking:

_____

12. Please list any supplements that your child is currently taking:

_____

13. What physical activities does your child currently participate in?

_____

14. Please list any emotional/social/or academic stressors in your child's life.

_____

15. Main Concern(s) for Child:

_____

_____

Family History/What Runs in the Family: _____
Lives with? (Siblings?): _____

Parent/Guardian Signature: _____Date: _____