Panacea Therapy Co
ADULT AND PEDIATRIC SERVICES

# PATIENT INTAKE FORM

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Date

Pediatrician

Child's Name

First

Last

Birth Date

Sex

Parent / Gaurdian Name

First

Last

Parent / Gaurdian Contact Number

Address

Street Address

Address Line 2

City

State / Province / Region

ZIP / Postal Code

Country

Email

School Attending

Grade / Level

Teacher's Name

First

Last

School Phone

Allergies: Please list any medication(s) or food(s) that your child is allergic to: ( I.E. latex, peanuts, etc.)

Please list any medications your child is taking

Does your child currently have any diagnoses?

Pleasex check any of the following evaluations / assessments that your cild has recived

- [ ] Physical Therapy Assessment
- [ ] Speech Therapy Assessment
- [ ] Psycho Eductional Assessment
- [ ] Visison Therapy Assessment

Please list any surguries, injueries, or illnesses your child has had to date

Please check any of the following whos care your child is under

- [ ] Pediatrician
- [ ] Psychologist
- [ ] Psychiatrist

- [ ] Psychiatrist
- [ ] Social Worker
- [ ] Physical Therapist
- [ ] Acupuncturist
- [ ] Occupational Therapist
- [ ] Speech Therapist

Does your child receive any of the following services at school?

- [ ] Occupational Therapy
- [ ] Physical Therapy
- [ ] Speech Therapy
- [ ] Counseling
- [ ] Support from a special educator
- [ ] Adaptive Physical Education
- [ ] Occupational Therapist
- [ ] Speech Therapist

Please describe the issue of concern at home and/or school, which has facilitated this evaluation:

## Background Information

Complications, illness/infections during pregnancy? Y / N (describe)

Complications during labor and delivery? Y / N (describe)

Forceps / Vacuum / C-section? Y / N (elaborate)

Birth Order

Birth Weight

Pre-Mature/Post-Mature/Full-Term?

- [ ] Pre-Mature
- [ ] Post-Mature
- [ ] Full-Term

Breast Fed?

- [ ] Yes
- [ ] No

Spit up frequently?

- [ ] Yes
- [ ] No

Problems with Feeding/Respiration/Sleeping? (describe)

Irritable/Happy/Quiet Baby?

- [ ] Irritable
- [ ] Happy
- [ ] Quiet

Did baby arch back & head when upset?

- [ ] Yes
- [ ] No

## Developmental Milestones

Sat

Belly Crawled

Crawled

Cruised

Walked

Said First Words

Talked

Undressed Self

Toilet Trained (Bladder & Bowels)

Dressed Self

Dressed Managed Snaps, Zippers, Buttons

Tied Shoes

Started Pre-school

Ear Infections? Y / N (How many, at what ages?)

Seizures? Y / N (describe)

Glasses? Y / N (If yes, please explain the type of prescription:)

Has the child had his or her vision checked within the past year?

If no, when was the last time the vision was checked and what were the results?

Age(s) and sex (es) of siblings

Age established?

Preferred hand?

- [ ] Left
- [ ] Right
- [ ] No preference

General Comments

SUBMIT

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