



General Intake

Please complete and return all forms BEFORE your scheduled appointment. If you have any questions, please contact a staff member by calling 857-307-3202 or emailing SRHFoxborough@partners.org.

Date Completed: ____/____/____

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____
 Date of Birth: ____/____/____ Sex: Male Female Nickname: _____
 Primary Language: _____ Secondary Language: _____
 Do you require an interpreter for your appointment? Yes No
 Parent/Guardian Name(s): _____
 Preferred Phone: _____ Email Address: _____

Referral Information

Service(s) Recommended:
 Physical Therapy Occupational Therapy Speech Therapy
 Brace/Equipment Clinic Social Skills Group Augmentative Communication
 Feeding Therapy Nutrition Other: _____
 Referral Reason/Primary Concerns: _____

 Referring Physician: _____ Specialty: _____
 Address: _____
 Phone: _____ Fax: _____

Behavioral History

Does the patient have a history of aggressive behavior towards self or others? Yes No
 If yes, please describe including potential triggers:

 Does the patient have any self-stimulatory, repetitive, or self-injurious behaviors? Yes No
 If yes, please describe including potential triggers:

 Does the patient live in a residential or group home setting? Yes No
 Does the patient require additional support staff due to behaviors? Yes No
If yes, please arrange for familiar staff to attend appointments with the patient.

Does the patient have a written behavioral support plan through school/home setting? Yes No
If yes, please attach plan.

Please list any behavioral plans in place or successful strategies such as star charts or token systems. What interventions have been successful?

Need for breaks? Yes No If yes, how often? _____

For evaluation purposes, does the patient have difficulty following directions or communicating? Yes No

What types of interventions have been helpful in assisting your child with following directions and making his or her wants and needs known?

Medical and Developmental History

Medical Diagnoses: _____

Please list any medical specialists the patient currently sees. (Neurology, Physiatry, GI, etc.)

Physician Name: _____ Specialty: _____
 Physician Name: _____ Specialty: _____
 Physician Name: _____ Specialty: _____

Please list any injuries, illnesses, or hospitalizations.

Event: _____ Date: _____
 Event: _____ Date: _____
 Event: _____ Date: _____

Please indicate any medical testing the patient has received.

Test	When?	By Whom?	Results?
<input type="checkbox"/> MRI			
<input type="checkbox"/> X-Rays			
<input type="checkbox"/> CT Scan			
<input type="checkbox"/> Neuropsych			
<input type="checkbox"/> Genetics			
<input type="checkbox"/> Hearing			
<input type="checkbox"/> Vision			
<input type="checkbox"/> Functional Visual Assessment			
<input type="checkbox"/> Swallow study (MBS, FEES)			

Does the patient have a history of seizures? Yes No

What kind? _____ How often? _____
 Date of Last? _____ Where? _____

Does the patient have a history of chronic ear infections? Yes No

Tubes placed? Yes No If yes, when? _____

Does the patient wear hearing aids? Yes No

Does the patient wear glasses? Yes No

Birth History: Was the patient born full term without complications? Yes No

If no, describe details of the pregnancy:

Please give approximate ages when the patient first performed the below skills.

Skill	Age	Skill	Age
Rolled over		Brushed teeth/Combed hair	
Sat unsupported		Undressed self	
Crawled		Completed fasteners	
Walked		Bathes self	
Babbled		Colored with crayons	
Said first words		Tied shoes	
Combined words		Hand preference	

Does the patient gain new skills consistently? Yes No

Has the patient ever had a regression (a time where he/she lost skills)? Yes No

Has the patient ever had a plateau (a time where he/she did not gain skills)? Yes No

If yes, please describe details of plateau or regression.

Does the patient have any siblings? Yes No

Please list sibling name, age, and any medical diagnosis we should be aware of.

Name: _____ Age: _____ Diagnosis: _____
 Name: _____ Age: _____ Diagnosis: _____
 Name: _____ Age: _____ Diagnosis: _____
 Name: _____ Age: _____ Diagnosis: _____

Mobility/Movement Status

Does the patient walk for all purposes? Yes No

Does the patient have weak muscles or fatigue quickly? Yes No

If yes, please describe: _____

What part of the body does the patient have the most control over?

Gen/4

Is the patient able to sit up well so that they can reach and point without difficulty? Yes No

What is the patient's hand dominance? Left Right

Does the patient demonstrate: Hand control? Finger control? Pointing ability?

Does the patient use adaptive equipment or orthotics? Yes No

If yes, please list.

Type: _____ Vendor: _____
Type: _____ Vendor: _____
Type: _____ Vendor: _____

Does the patient have a wheelchair or specialty seating? Yes No

If yes, please list.

Type: _____ Vendor: _____
Type: _____ Vendor: _____
Type: _____ Vendor: _____

Interests and Current Interventions

Interests

Please indicate below the types of things the patient likes or dislikes.

Musical Toys	Likes <input type="checkbox"/>	Dislikes <input type="checkbox"/>	Drawing/ Coloring	Likes <input type="checkbox"/>	Dislikes <input type="checkbox"/>
Loud noises	Likes <input type="checkbox"/>	Dislikes <input type="checkbox"/>	Computers/ video games	Likes <input type="checkbox"/>	Dislikes <input type="checkbox"/>
Different textures	Likes <input type="checkbox"/>	Dislikes <input type="checkbox"/>	Other children	Likes <input type="checkbox"/>	Dislikes <input type="checkbox"/>
New people	Likes <input type="checkbox"/>	Dislikes <input type="checkbox"/>	Other: _____	Likes <input type="checkbox"/>	Dislikes <input type="checkbox"/>

Favorite toys or activities?

Favorite TV shows/movies, books, characters?

School

School Name: _____ District: _____

Grade Level: _____ Type of classroom: Typical Inclusion Seclusion Other: _____

Does the patient have any special supports in the classroom (i.e.1:1 aide)? Yes No

If yes, please describe: _____

Previous Evaluations: Indicate if the patient has participated in any of the below evaluations within the last year.

Please bring copies of the evaluation(s) or send them prior to your appointment.

Therapy	Date of Evaluation	Location
<input type="checkbox"/> PT Evaluation	Date: _____	<input type="checkbox"/> School <input type="checkbox"/> Outpatient <input type="checkbox"/> Early Intervention <input type="checkbox"/> Private
<input type="checkbox"/> OT Evaluation	Date: _____	<input type="checkbox"/> School <input type="checkbox"/> Outpatient <input type="checkbox"/> Early Intervention <input type="checkbox"/> Private
<input type="checkbox"/> Speech Evaluation	Date: _____	<input type="checkbox"/> School <input type="checkbox"/> Outpatient <input type="checkbox"/> Early Intervention <input type="checkbox"/> Private
<input type="checkbox"/> AAC Evaluation	Date: _____	<input type="checkbox"/> School <input type="checkbox"/> Outpatient <input type="checkbox"/> Early Intervention <input type="checkbox"/> Private
<input type="checkbox"/> Feeding Evaluation	Date: _____	<input type="checkbox"/> School <input type="checkbox"/> Outpatient <input type="checkbox"/> Early Intervention <input type="checkbox"/> Private

Current Services: Please indicate below all services the patient is currently receiving, including extracurricular activities.

Intervention	Location				How Often?
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> School	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Early Intervention	<input type="checkbox"/> Private	Times per week? _____ How many minutes? _____
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> School	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Early Intervention	<input type="checkbox"/> Private	Times per week? _____ How many minutes? _____
<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> School	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Early Intervention	<input type="checkbox"/> Private	Times per week? _____ How many minutes? _____
<input type="checkbox"/> Group Therapy	<input type="checkbox"/> School	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Early Intervention	<input type="checkbox"/> Private	Times per week? _____ How many minutes? _____
<input type="checkbox"/> ABA	<input type="checkbox"/> School	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Early Intervention	<input type="checkbox"/> Private	Times per week? _____ How many minutes? _____
<input type="checkbox"/> Home Services	<input type="checkbox"/> School	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Early Intervention	<input type="checkbox"/> Private	Times per week? _____ How many minutes? _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> School	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Early Intervention	<input type="checkbox"/> Private	Times per week? _____ How many minutes? _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> School	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Early Intervention	<input type="checkbox"/> Private	Times per week? _____ How many minutes? _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> School	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Early Intervention	<input type="checkbox"/> Private	Times per week? _____ How many minutes? _____

Prior to Appointment Date

- Complete and return all forms BEFORE your appointment. Forms can be emailed to srhfoxborough@partners.org, faxed to 857-307-3267, or mailed to SRH Foxborough, 22 Patriot Place, Ste 120, Foxborough, MA 02035.
- If your insurance requires referrals, call the patient’s primary care physician to request a referral for your appointment(s), dated to start on or before the appointment date. Spaulding’s national provider number or NPI is 1780600825.
- Please send copies of any PT/OT/Speech evaluations from within the last year, current IEP, and Behavioral Support Plan. (If you are unable to send these prior, please bring them with you to the appointment.)
- If the patient requires additional support staff due to behavior, please arrange for familiar staff to attend the appointments with the patient.

On the Appointment Date

- A parent/guardian must attend the patient’s first visit to complete and sign any required consent forms.
- Bring a copy of the patient’s insurance card(s) and a photo ID (if applicable).
- Bring any braces, adaptive equipment, communication books, boards, or devices that the patient uses.
- If you anticipate that the patient may have difficulty in participating in the appointment, please bring any special reinforcers such as a book, small toy, or snack.