**General Intake**

Please complete and return all forms BEFORE your scheduled appointment. If you have any questions, please contact a staff member by calling 781-860-1742 or emailing SRHLexington@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? |
|---|---|---|---|
| ☐ MRI | | | |
| ☐ X-Rays | | | |
| ☐ CT Scan | | | |
| ☐ Neuropsych | | | |
| ☐ Genetics | | | |
| ☐ Hearing | | | |
| ☐ Vision | | | |
| ☐ Functional Visual Assessment | | | |
| ☐ 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?

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 ☐ | Dislikes ☐ | Drawing/ Coloring | Likes ☐ | Dislikes ☐ |
| Loud noises | Likes ☐ | Dislikes ☐ | Computers/ video games | Likes ☐ | Dislikes ☐ |
| Different textures | Likes ☐ | Dislikes ☐ | Other children | Likes ☐ | Dislikes ☐ |
| New people | Likes ☐ | Dislikes ☐ | Other: _____ | Likes ☐ | Dislikes ☐ |

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 | | | |
|---|---|---|---|---|---|
| ☐ PT Evaluation | Date: _____ | ☐ School | ☐ Outpatient | ☐ Early Intervention | ☐ Private |
| ☐ OT Evaluation | Date: _____ | ☐ School | ☐ Outpatient | ☐ Early Intervention | ☐ Private |
| ☐ Speech Evaluation | Date: _____ | ☐ School | ☐ Outpatient | ☐ Early Intervention | ☐ Private |
| ☐ AAC Evaluation | Date: _____ | ☐ School | ☐ Outpatient | ☐ Early Intervention | ☐ Private |
| ☐ Feeding Evaluation | Date: _____ | ☐ School | ☐ Outpatient | ☐ Early Intervention | ☐ Private |

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

| Intervention | Location | How Often? |
|---|---|---|
| ☐ Physical Therapy | ☐ School ☐ Outpatient ☐ Early Intervention ☐ Private | Times per week? _____<br>How many minutes? _____ |
| ☐ Occupational Therapy | ☐ School ☐ Outpatient ☐ Early Intervention ☐ Private | Times per week? _____<br>How many minutes? _____ |
| ☐ Speech Therapy | ☐ School ☐ Outpatient ☐ Early Intervention ☐ Private | Times per week? _____<br>How many minutes? _____ |
| ☐ Group Therapy | ☐ School ☐ Outpatient ☐ Early Intervention ☐ Private | Times per week? _____<br>How many minutes? _____ |
| ☐ ABA | ☐ School ☐ Outpatient ☐ Early Intervention ☐ Private | Times per week? _____<br>How many minutes? _____ |
| ☐ Home Services | ☐ School ☐ Outpatient ☐ Early Intervention ☐ Private | Times per week? _____<br>How many minutes? _____ |
| ☐ Other: _____ | ☐ School ☐ Outpatient ☐ Early Intervention ☐ Private | Times per week? _____<br>How many minutes? _____ |
| ☐ Other: _____ | ☐ School ☐ Outpatient ☐ Early Intervention ☐ Private | Times per week? _____<br>How many minutes? _____ |
| ☐ Other: _____ | ☐ School ☐ Outpatient ☐ Early Intervention ☐ Private | Times per week? _____<br>How many minutes? _____ |

**Prior to Appointment Date**

- Complete and return all forms BEFORE your appointment. Forms can be emailed to srhlexington@partners.org, faxed to 781-860-1769, or mailed to SRH Lexington, 1 Maguire Rd, Lexington, MA 02421.
- 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.