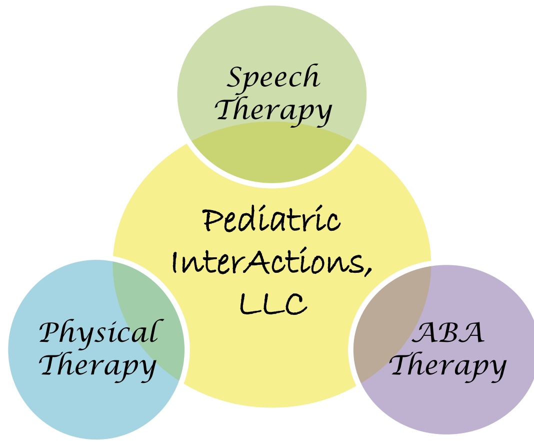

47 Wilson Ave. (Route 527), Manalapan, NJ 07726

Phone: 732-617-6797

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PediatricInteractionsNJ@gmail.com

Intake Form

Date:____________________

Child's Name: ________________________________ D.O.B:________________ ☐ M ☐ F

Parent/Guardian's Name:____

Address:______________________________________City:________________ Zip Code:______

Home Phone:________________________ Cell Phone:______________________________

Email:______________________________

Emergency Contact:____

Address:______________________________________City:________________ Zip Code:______

Home Phone:________________________ Cell Phone:________________________________

Child's Siblings: (list first name and ages in/out of home)

____

____

Primary Language Spoken at Home:____

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1. How did you hear about us?____
2. Referred by (if applicable) :____
3. What is the reason for seeking treatment?_____________________________________
4. Primary Diagnosis (, developmental disability,ADHD, ASD.):_________________________
   Name of clinician/physician providing diagnosis:__________________________________
5. Age of your child at time of diagnosis:__________________
6. Does your child have any other medical conditions? _______________________________
   ____

7. Is your child on any medications or have any allergies? Yes/No
   If Yes,specify:____
   ____

8. Describe the challenges your child exhibits and reason for seeking treatment:
   ____
   ____
   ____
   ____

9. Does your child currently have an IEP? Yes/No If Yes, specify current program and classification:____

10. Will you provide a copy of your child's current IEP/updated evaluations for intake purposes? ____
    *The IEP provides Pediatric InterActions with pertinent information including but not limited to summaries of medical history, summaries of previous evaluations, current and prior treatments provided including therapeutic interventions, relevant family history.

11. Is your child currently receiving therapy services? Yes/No If Yes, please specify the type of therapy, frequency, and location:____
    ____
    ____

12. What community resources is your child currently participating in?(i.e., recreation programs, play groups, extracurricular activities, etc.)
    ____
    ____

13. Does your child participate in any cultural, vocational, or spiritual activities/services?
    ____

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14. How would you describe your child's general affect/mood?____________________________
    ____

15. What are your child's likes/interests:
    ____
    ____
    ____

16. What are your child's dislikes:
    ____
    ____
    ____

17. What are your child's strengths:
    ____
    ____
    ____

18. What are your child's areas of need:

    ____

    ____

    ____

19. What are short-term goals you would like your child to acquire:

    ____

    ____

    ____

20. At Pediatric InterActions we feel strongly about establishing a collaborative relationship with families in order to promote generalization of skills as well as provide resources and supports for the home and community settings. Therapists will provide the family/caregiver with a brief summary after each therapy session discussing the current topics and skills adressed that day. A structured parent training session that is individualized to the family and child's needs is also available as an additional service. If you would be interested in participating in a parent training session please circle your response: Yes/No

OFFICE USE:
Type of therapy services requested:
Availability for services (indicate all days and times):