Mass General Brigham
Spaulding Rehabilitation

Date Completed:_____

General Intake

Patient Information

Patient Name: _____ Preferred Name: _____

Date of Birth: _____ Primary Language:_____

Legal Sex: ☐ Male ☐ Female ☐ X Gender Identity: _____ Preferred Pronouns: _____

Referral Information

Referring Physician: _____

Referral Reason/Primary Concerns:_____

_____

Do you have any additional concerns related to (please select):

☐ Strength	☐ Fine Motor	☐ Self Help Skills	☐ Handwriting	☐ Sensory Processing
☐ Feeding	☐ Balance	☐ Social Skills	☐ Attention	☐ Gross Motor Movements
☐ Coordination	☐ Communication	☐ Frustration Tolerance	☐ Behavior	☐ Safety

Medical and Developmental History

Medical History/Diagnosis: _____

_____

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

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

Please list any injuries, surgeries, or hospitalizations.

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

Birth History: Was the patient born at full term without complications: ☐ Yes ☐ No
If no, describe details of the pregnancy, delivery and any postnatal special care/NICU:

_____

_____

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

Skill	Age	Skill	Age	Skill	Age
Rolled over		Walked		Crawled	
Sat unsupported		Said first words		Combined words	

Please list any allergies the patient has:

_____

Please list any medications the patient is taking:

Medication Name	Dose	What is it treating?

Behavioral History

Does the patient have a history of aggressive behavior towards self or others? ☐ Yes ☐ No

If yes, please describe including potential triggers, behavioral plans, and successful strategies:

_____

_____

Current Interventions

School:

School Name:_____ District:_____ Grade Level:_____

Does the patient have an IEP or 504 plan? ☐ Yes ☐ No

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? _____ How many minutes? _____
☐ Occupational Therapy	◯ School	◯ Outpatient	◯ Early Intervention	◯ Private	Times per week? _____ How many minutes? _____
☐ Speech Therapy	◯ School	◯ Outpatient	◯ Early Intervention	◯ Private	Times per week? _____ How many minutes? _____
☐ Group Therapy	◯ School	◯ Outpatient	◯ Early Intervention	◯ Private	Times per week? _____ How many minutes? _____
☐ ABA Therapy	◯ School	◯ Outpatient	◯ Early Intervention	◯ Private	Times per week? _____ How many minutes? _____
☐ Home Services	◯ School	◯ Outpatient	◯ Early Intervention	◯ Private	Times per week? _____ How many minutes? _____
☐ Other:	◯ School	◯ Outpatient	◯ Early Intervention	◯ Private	Times per week? _____ How many minutes? _____

Previous Services – Has the patient previously received any of the following:

◯ Physical Therapy ◯ Occupational Therapy ◯ Speech Therapy ◯ ABA ◯ Early Intervention ◯ Feeding Therapy

Many standardized tests cannot be repeated within one year's time. Please bring or send a copy of any PT, OT, Speech evaluations done within the last year. If your child has an IEP/IFSP or has neuropsychology testing, please bring a copy.

Members of child's household:

Name: _____ Age:_____ Relationship: _____

Name: _____ Age:_____ Relationship: _____

Name: _____ Age:_____ Relationship: _____

Name: _____ Age:_____ Relationship: _____

Name: _____ Age:_____ Relationship: _____

Parent/Guardian Signature:_____ Date: _____

Relationship to patient: _____