



278 Monmouth St., Suite 1  
Jersey City, NJ 07302  
(201) 324-1700  
Fax: (201) 324-1788

**PATIENT INTAKE/PARENT QUESTIONNAIRE**

Please provide us with the following information so we can best serve your child.

Today's Date: \_\_\_ / \_\_\_ / \_\_\_

Name of person completing this form and relationship to child:

\_\_\_\_\_

Name of Child: \_\_\_\_\_

Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_\_\_ Sex: F  M

Parent's Names: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Language(s) Spoken: \_\_\_\_\_

Siblings Names and Ages:

\_\_\_\_\_

\_\_\_\_\_

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Home Address: \_\_\_\_\_

Work Address: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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Who referred you? \_\_\_\_\_

How did you learn about Sensory Kids LLC?

\_\_\_\_\_

Why are you seeking our services?

\_\_\_\_\_

\_\_\_\_\_

Child's Physician(s) \_\_\_\_\_

Other Health Professionals, Agencies, or Medical Professionals working with your child?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List current school or childcare provider:

\_\_\_\_\_

\_\_\_\_\_

List previous school/daycare experiences:

\_\_\_\_\_

\_\_\_\_\_

List services your child receives in school: (i.e.- OT, PT, S/L, EH, TMH, etc...)

\_\_\_\_\_

\_\_\_\_\_

**TELL US MORE ABOUT YOUR CHILD**

Please answer the following to the best of your knowledge:

Describe your child's development as compared to other children of the same age:

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What are child's strength's?

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What do you find difficult for your child to accomplish?

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Does your child have difficulty understanding or following directions?

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Describe how your child gets along with other children:

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**YOUR CHILD'S LIKES/DISLIKES**

Please answer the following to the best of your knowledge:

What does your child's dislike?

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Please list your child's favorite play activities/toys?

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What are your child's favorite foods?

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Is your child a picky eater? Yes  No  If so, please explain below:

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**YOUR CHILD'S PAST MEDICAL HISTORY**

Please answer the following to the best of your knowledge:

Has your child had any ear infections? Yes  No

If so, please indicate how often and how they were treated for it below:

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Does your child seem overly sensitive to noises, light crowds/groups, texture/touch, clothing, (etc...) Yes  No

If so, please describe below:

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Does your child grind their teeth during the day/or night? Yes  No   
If so, do they clench their jaw? Yes  No

If so, please describe below:

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Please describe any family history of health, mental, emotional, or learning difficulties:

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**YOUR COMMENTS/CONCERNS**

Please answer the following to the best of your knowledge:

Please describe mealtime routines or concerns:

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Please describe bedtime routines or concerns:

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Please describe any toileting concerns:

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Please share any other information that you feel will be helpful to us in working with your child/family:

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**PAYMENTS**

I understand and I am financially responsible for paying my total bill within 90 days of treatment, (whether my insurance company has made payment or not), and agree that if any bills is not paid within 90 days from the date of treatment, my bill may be sent to a collection agency where my credit will be affected. Furthermore, I am responsible for any legal, interest, or collection costs associated with my account.

Please sign and return.

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(Print Name : \_\_\_\_\_)

Thank you for your cooperation in filling out this form!!!