THOMSON PAEDIATRIC CENTRE
The Child Development Centre

Intake Form

To help us make most of your appointment, we would appreciate if you could fill in this form. The information would help our staff have an understanding of your concerns and your child's difficulties. The information will be kept strictly confidential. Your permission will be sought if any disclosure of information is needed. Thank you.

A) CHILD'S DETAILS

Name: _____ **Gender**: Male / Female
Surname *Given Name(s)*

Date of Birth: _____ / _____ / _____ **Birth Cert. No.** : _____
Date / Month / Year

Nationality: _____

Race: Chinese / Malay / Indian / Eurasian / Others (Pls specify: ……)

Language spoken by child: _____

Language(s) used at home: _____

B) REFERRAL REASON

What is(are) the reason(s) for this referral? (e.g., What are your concerns? What are your child's difficulties?)

_____

_____

_____

Please indicate a tick (✓) in the boxes below:

Are your concerns ☐ recent ☐ ongoing?

How long have your child shown the difficulties? _____(*no. of yrs / mths*)

Please indicate which aspect(s) of your child's life is(are) affected?

☐ Family relationships ☐ School/ Learning ☐ Peer interactions ☐ Independence (self-help)
☐ Play ☐ Diet ☐ Sleep ☐ Speech ☐ Gross motor skills (walking, running)
☐ Fine motor skills (handwriting)

What do you hope to learn from engaging services at Thomson Paediatric Centre?

_____

_____

_____

C) FAMILY BACKGROUND

FATHER	*MOTHER*
Name: _____	**Name**: _____
Tel: _____(H/HP)	**Tel**: _____(H/HP)
Martial Status: Married / Divorced/ Widowed	**Martial Status**: Married / Divorced/ Widowed
Highest Qualification: ☐ Primary ☐ Diploma ☐ Secondary ☐ Graduate ☐ 'A' Levels ☐ Post-Graduate	**Highest Qualification**: ☐ Primary ☐ Diploma ☐ Secondary ☐ Graduate ☐ 'A' Levels ☐ Post-Graduate
Occupation: _____	**Occupation**: _____

SIBLINGS

	GENDER	*AGE (yrs)*	*NAME OF SCHOOL*	*LEVEL*
1.	Male / Female	_____	_____	_____
2.	Male / Female	_____	_____	_____
3.	Male / Female	_____	_____	_____
4.	Male / Female	_____	_____	_____

Please indicate (✓) the main caregiver(s):

☐ Parent(s) ☐ Grandparents ☐ Aunt / Uncle ☐ Maid / Helper ☐ Others (Pls specify:…….)

D) BIRTH HISTORY

Pregnancy Length (*weeks*): _____ **Birth Weight**: _____

Birth Procedure (e.g., normal, breech, caesarean): _____

Any problems/complications during pregnancy?
□ Yes (Pls specify: ……..)
□ No

Any complications occur for child or mother during and immediately after birth?
□ Yes (Pls specify: ……..)
□ No

E) DEVELOPMENTAL HISTORY

If known, at what age (*months*) **did your child master the following skills**:

Language
First words: _____ Use 2 word sentence _____ Use full sentences _____

Motor
Crawl: _____ Walk (unassisted): _____ Self-feed: _____ Catch a ball: _____

Was/Is your child clumsy in walking? □ Yes □ No **Was/Is your child clumsy in using hands?** □ Yes □ No

Behaviour
Any difficulty getting along with friends: □ Yes □ No

Any difficulty getting along with adults (e.g., parents, teachers, aunt/uncle): □ Yes □ No

F) HEALTH & MEDICAL HISTORY

Has your child suffered any major illness/surgery/fits?
□ Yes (Pls specify: ……)
□ No

Has your child been on or is he/she now taking prescription medication
□ Yes (Pls specify: ……)
□ No

Has your child been examined for the following : *If yes, when and results*

Hearing test _____

Vision test _____

Please indicate (✓) past or present involvement with the following health professions

	Past	*Present*	*Treatment Focus / Length of Involvement*
Occupational Therapist	☐	☐	_____
Speech Therapist	☐	☐	_____
Neurologist	☐	☐	_____
Psychologist	☐	☐	_____
Physiotherapist	☐	☐	_____
Psychiatrist	☐	☐	_____

G) EDUCATIONAL DETAILS

Name of School: _____

Grade: Nursery / Kindergarten / Primary / Secondary **Level**: 1 / 2 / 3 / 4 / 5 / 6 **Stream**: Express
Normal (Academic)
Normal (Tech)

Did/Does your child attend kindergarten? ☐ Yes ☐ No

Previous School Attended:

Name of School	*Length of Time Attended* (*mths/yrs*)
_____	_____
_____	_____

Is your child attending or have your child attended Learning Support Program (LSP) in school?
☐ Yes ☐ No

Is your child attending extra classes after school (e.g., tuition)? ☐ Yes ☐ No

What do his/her teachers say about your child?

_____

_____

Current academic performances:

Subject	*Grade (e.g., % or Band 1, 2, 3, 4)*
English	_____
Math	_____
Mother Tongue	_____
Science (if applicable)	_____

NOTE: If you have copies of your child's academic results, please send them together with this form.

H) CONTACT DETAILS

Who should the Clinic contact to discuss your child's concerns or arrange a time for the assessment?

Name: _____ Tel: _____ (H/HP)

Relationship to the Child: Father / Mother / Others (Pls specify: ……...)

Language which you prefer to speak with our professionals:

English / Mandarin / Others (Pls specify : ……)

How did you hear about our centre:

□ School □ Newspapers □ Brochures □ Magazines □ Doctor □ Website
□ Friends □ Others (Pls specify……..….)

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