



**Well Baby Center®**  
**www.wellbabycenter.org**  
**310-402-BABY (2229)**

**IPI Transitions**  
**Child and Family Intake Form**

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Current Age: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Sibling Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Sibling Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

What concerns do you have about your child? \_\_\_\_\_

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Professionals consulted (include previous assessments, reports, etc.):

Primary Pediatrician \_\_\_\_\_

Developmental Pediatrician \_\_\_\_\_ Neurologist \_\_\_\_\_

Psychiatrist \_\_\_\_\_ Psychologist \_\_\_\_\_

OT \_\_\_\_\_ PT \_\_\_\_\_

Speech \_\_\_\_\_ Therapeutic Companion \_\_\_\_\_

IPP \_\_\_\_\_ Other \_\_\_\_\_

What have you done to address the concern (s) so far? \_\_\_\_\_

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**RELEVANT BACKGROUND:**

**Pregnancy and delivery**

Length \_\_\_\_\_ months? Was the timing of the pregnancy good for you? \_\_\_\_\_

Any complications during pregnancy? \_\_\_\_\_

Any medications taken during pregnancy? \_\_\_\_\_

How did you feel about the pregnancy? \_\_\_\_\_ How did your

Partner/spouse feel about the pregnancy? \_\_\_\_\_

What was your mood during pregnancy? \_\_\_\_\_ And after? \_\_\_\_\_

Type of delivery? \_\_\_\_\_ Birth weight? \_\_\_\_\_ Complications? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Emotional reaction to child? \_\_\_\_\_

Baby's temperament? \_\_\_\_\_

Breast fed? \_\_\_\_\_ Bottle fed? \_\_\_\_\_ How did weaning go? \_\_\_\_\_

Problems with feeding? \_\_\_\_\_ Problems with sleeping? \_\_\_\_\_

Problems in the marital relationship? \_\_\_\_\_

**Developmental milestones**

Sat up at \_\_\_\_\_ Crawled at \_\_\_\_\_ Walked at \_\_\_\_\_

First words \_\_\_\_\_ Spoke in sentences \_\_\_\_\_

Toilet training accomplished (yes/no) \_\_\_\_\_ at \_\_\_\_\_ Difficulties? \_\_\_\_\_

**Medical History**

Chronic Illness \_\_\_\_\_ Hospitalization \_\_\_\_\_ Surgeries \_\_\_\_\_

Ear infections \_\_\_\_\_ Strep \_\_\_\_\_ Allergies \_\_\_\_\_ Asthma \_\_\_\_\_

Other \_\_\_\_\_

**Childcare or Preschool Experiences**

School \_\_\_\_\_ Telephone \_\_\_\_\_ Director \_\_\_\_\_

Teacher \_\_\_\_\_ Time/Days \_\_\_\_\_

Age started \_\_\_\_\_ Reaction to separation/and process \_\_\_\_\_

\_\_\_\_\_



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Relationship with teachers/caregivers \_\_\_\_\_ With other children \_\_\_\_\_

Concerns of teachers or caregivers \_\_\_\_\_

**Sensory Integration -- Does your child either seek-out, avoid, or over-react to:**

noises? \_\_\_\_\_ bright lights? \_\_\_\_\_ touch ? \_\_\_\_\_ smells? \_\_\_\_\_

food textures? \_\_\_\_\_ clothing? \_\_\_\_\_ movement? \_\_\_\_\_

Have there been any long separations, losses, exposure to extreme family conflict or traumas, etc. in your child's life? Please describe. \_\_\_\_\_

\_\_\_\_\_

Please describe your child's personality. \_\_\_\_\_

\_\_\_\_\_

Please describe your child's relationship to you.

Mom \_\_\_\_\_

\_\_\_\_\_

Dad \_\_\_\_\_

\_\_\_\_\_

Describe your parenting style. Your attitude toward discipline? Structure?  
Comfort level with expressing a range of feelings? How well do you parent together?

Mom \_\_\_\_\_

\_\_\_\_\_

Dad \_\_\_\_\_

\_\_\_\_\_

What does your child like to do? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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What does your child not like to do? \_\_\_\_\_

**Describe your child's ability to handle**

Separations \_\_\_\_\_

New situations and people \_\_\_\_\_

Frustration \_\_\_\_\_

Limit Setting \_\_\_\_\_

Transition times \_\_\_\_\_

Expressing him/herself emotionally \_\_\_\_\_

Soothing him/herself \_\_\_\_\_

Recovery from distress \_\_\_\_\_

Self-Care (dress, feed, brush teeth, use toilet, etc.) \_\_\_\_\_

**Do you have concerns in the following areas:**

Making eye contact \_\_\_\_\_

Answering to his name \_\_\_\_\_

Arching back when being held \_\_\_\_\_

Excessive crying \_\_\_\_\_

Not pointing or mutually engaging \_\_\_\_\_

Fine motor skills \_\_\_\_\_ Gross motor skills \_\_\_\_\_

Sleeping \_\_\_\_\_

Eating \_\_\_\_\_

Aggression \_\_\_\_\_

Behavioral concerns \_\_\_\_\_

Temper tantrums \_\_\_\_\_

Social interactions with peers \_\_\_\_\_

Social interactions with adults \_\_\_\_\_

Passivity or lack of interest in things \_\_\_\_\_

Other \_\_\_\_\_



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**Speech and Language**

At approximately what age did your child begin to...Point at things \_\_\_\_\_

Coo and babble \_\_\_\_\_ First words \_\_\_\_\_ Name things \_\_\_\_\_

Combine two words \_\_\_\_\_ Use short sentences \_\_\_\_\_

Ask questions \_\_\_\_\_ Answer questions \_\_\_\_\_

Imitate movements \_\_\_\_\_ Identify needs \_\_\_\_\_

How does your child usually let you know what he/she wants? (Please circle all that apply)

Cries                      Points                      Uses gestures                      Makes a few sounds

Uses one word                      Two or three word sentences                      Uses long sentences

Other comments \_\_\_\_\_  
\_\_\_\_\_

Please circle the amount that describes your child's vocabulary:

0 – 50 words    50 – 100 words    100 – 500 words    500 – 1000 words    1000+ words

Please describe your child's feeding and eating development: (picky eater, aversions, chewing or swallowing difficulties) \_\_\_\_\_

\_\_\_\_\_ Allergies? \_\_\_\_\_

Intake Completed by \_\_\_\_\_ Date \_\_\_\_\_

License # and Signature \_\_\_\_\_