INITIAL INTAKE FORM

OCCUPATIONAL THERAPY, SPEECH THERAPY, PHYSICAL THERAPYand SPECIAL EDUCATIONAL SERVICES

CLIENT INFORMATION

Patient Name	
Date of Birth	
Gender	
Parent/Guardian Name	
Address	
City, State, Zip	
Home Phone	
Cell Phone	
Email Address	
Daytime Caregiver's name	
Language(s) Spoken in Home	
Pediatrician full name and number	
Other Children in Family Ages of siblings	

BACKGROUND INFORMATION

Describe your primary concern(s) regarding your child	
At what age did you first become concerned?	
Are there any other family members with a history of developmental concerns (i.e. learning disabilities, developmental delays, autism, etc.)	

PRENATAL/BIRTH HISTORY

History of pregnancy (i.e., medication, health of mother, complications):				
Length of pregnancy	**Full Term**			**Weeks Gestation**
	Premature			**Weeks Gestation**
Type of delivery		**Vaginal**	**C-Section**	**Breech**
Note complications of labor/delivery, including medications				
Birth Weight				
Length of Hospital Stay				
Did/Does your child have difficulty		**Sucking**	**Yes**	**No**
		Swallowing	**Yes**	**No**
		Chewing	**Yes**	**No**
		Changing to solids	**Yes**	**No**

DEVELOPMENTAL HISTORY

Present level of activity	**Active**	**Typical**	**Low Arousal**
Developmental Milestones in Early Infancy	**Sat alone**	**Crawling**	**Walking**
	Babbling	**First Words**	**Sentences**
Present Behavioral Concerns			
Present Sleep Habits **Does your child put him/herself to sleep?** **Do you rock/lay with them, etc.?** **Hours of sleep at night:** **Hours of sleep at naptime:**			

MEDICAL HISTORY

List past/present medications:	
List any diagnosis as well as any significant illnesses and or infections (give approximate dates):	
List surgeries or hospitalizations (give approximate dates):	
List any allergies (food and non-food):	
Did/does your child suffer from frequent ear infections? If yes, list the number since birth	

The following questions are used as a tool in order to create a more clear and complete picture of your child from early infancy to his/her present developmental stage. Some of the questions may not apply to your child depending upon his or her age. Please cross out the item that does not apply. Circle the choice that applies and add narrative information if necessary. Thank you for your time.

SPEECH-LANGUAGE DEVELOPMENT

Was your infant	**A quiet baby**	**Yes**	**No**
	A frequent crier	**Yes**	**No**
	Irritable	**Yes**	**No**
	Interested in looking at things in their environment	**Yes**	**No**
	Alert/attentive to sounds	**Yes**	**No**
At what age did your child	**Babble**		
	Understand routine words/phrases (go bye bye, etc.)		
	Imitate Speech Sounds		
	Say first words		
	Use two or more words in a phrase		
Did your child begin to babble and then stop?			
At present, does your child have:	**Understandable speech**	**Yes**	**No**
	A loud voice	**Yes**	**No**
	A monotone voice	**Yes**	**No**
	A hoarse voice	**Yes**	**No**
Does your child:	**Respond to sound**	**Yes**	**No**
	Respond to loud noises only	**Yes**	**No**

EDUCATIONAL BACKGROUND

Name of Present School/Daycare	
Names of Past Schools/Daycares	
Grade	
School Address	
School City, State, Zip	
School Phone	
Teacher's name	
Related Services (OT, PT, SLP, SW)	
Does your child receive any out of school, supplemental services? If so, please list/describe	
Concerns in Academic/Cognitive areas?	
Concerns with Play Skills?	
Concerns with Everyday Living Skills?	
Concerns with Social Skills?	
Does your child attend any out of school classes? (i.e., Mommy and Me, My Gym, music, etc.)	

FUNCTIONAL STATUS

Eating and drinking **Does your child**	**Use a spoon**	**Yes**	**No**
	Use a fork	**Yes**	**No**
	Use a knife	**Yes**	**No**
	Drink from an open cup	**Yes**	**No**
	Drink from a straw	**Yes**	**No**
Clothing Management **Does your child**	**Remove clothing**	**Yes**	**No**
	Put on clothing	**Yes**	**No**
	Engage the foot of zippers	**Yes**	**No**
	Fasten buttons	**Yes**	**No**
	Tie shoelaces	**Yes**	**No**
Toileting **Does your child**	**Use the bathroom independently**	**Yes**	**No**

SENSORIMOTOR HISTORY

TOUCH

Does your child	**Become upset when his/her hair is cut**	**Yes**	**No**
	Dislike having hair combed or washed	**Yes**	**No**
	Dislike when his/her hands are messy	**Yes**	**No**
	Decreased tolerance for having nails trimmed	**Yes**	**No**
	Dislike the feeling of sand or grass	**Yes**	**No**
	Avoid being barefoot on different surfaces i.e. grass, sand, carpet, tile flooring	**Yes**	**No**
	Become upset when someone sits too close or brushes against them	**Yes**	**No**
	Constantly touch objects or people	**Yes**	**No**
	Seem unaware of food or liquid left on lips or around	**Yes**	**No**

	mouth		
	Sit too close to other people or lies on top of them	**Yes**	**No**
	Pinch, bite or otherwise hurt him/herself	**Yes**	**No**
	Frequently bump or push others	**Yes**	**No**
	Dislike crowded places or close spaces	**Yes**	**No**
	Not cry when seriously hurt	**Yes**	**No**
Comments:			

MOVEMENT

Does your child	**Like rough housing, horse play, rough and tumble**	**Yes**	**No**
	Like being tossed in the air	**Yes**	**No**
	Like to turn in circles	**Yes**	**No**
	Like the swings and slide at the park	**Yes**	**No**
	Like to jump	**Yes**	**No**
	Have difficulty with sitting still	**Yes**	**No**
	Like to crash to the floor or on furniture	**Yes**	**No**
	Get carsick easily	**Yes**	**No**
	Get nauseous and/or vomit easily	**Yes**	**No**
	Have fear of stairs, heights etc.	**Yes**	**No**
	Lose his/her balance easily	**Yes**	**No**
	Walk on his/her toes	**Yes**	**No**
	Like being upside down (somersaults etc.)	**Yes**	**No**
	Prefer to be sedentary or still (computer or television) over playing outside	**Yes**	**No**
Comments:			

VISUAL

Does your child	Have a diagnosed vision problem	Yes	No
	Have trouble following with his/her eyes	Yes	No
	Avoid eye contact with others	Yes	No
	Have trouble copying from the board	Yes	No
	Dislike having eyes covered	Yes	No
	Make reversals when copying letters	Yes	No
	Have trouble discriminating shapes, colors correctly	Yes	No
	Squint often (when reading or outside in the sun)	Yes	No
	Prefer to be in the dark	Yes	No
	Like to watch things that spin	Yes	No
	Spin objects or toys such as wheels on cars etc.	Yes	No
Comments:			

TASTE & SMELL

Does your child	Chew on non-food items	Yes	No
	Demonstrate being an EXTREMELY picky eater	Yes	No
	Have trouble eating different textured foods	Yes	No
	Sensitive or insensitive to noxious smells/tastes	Yes	No
	Taste or smell objects when playing with them	Yes	No
	Prefer spicy, sour, bitter food flavors	Yes	No
Comments:			

SOUND

Does your child	Have a diagnosed hearing problem	Yes	No
	Have PE tubes in his/her ears	Yes	No
	Have frequent ear infections	Yes	No
	Show difficulty or is bothered by loud noises	Yes	No
	Respond negatively to loud or unexpected noises	Yes	No
	Over attend to background noise such as the refrigerator , fluorescent light bulbs, fans when trying to work	Yes	No
	Ignore you or fail to listen when you're speaking to him/her	Yes	No
	Like to play music at loud volumes	Yes	No
	Like to sing or dance to music	Yes	No
	Have difficulty with following directions with more than one step	Yes	No
	Talk excessively or fail to wait for his/her turn	Yes	No
	Have a delay in speech development	Yes	No
Comments:			

BEHAVIOR/TEMPERAMENT

	Quiet, calm, relaxed, patient	Yes	No
	Active, outgoing, enthusiastic	Yes	No
	Intense, demanding	Yes	No
	Seem hyperactive, always in motion	Yes	No
	Upset by changes to routine, transitions	Yes	No

Is your child	**Passive, quiet, withdrawn**	**Yes**	**No**
	Rigid, set in his/her ways	**Yes**	**No**
	Regular sleep patterns	**Yes**	**No**
	Difficult to get to sleep	**Yes**	**No**
	Destructive with toys	**Yes**	**No**
	Short attention span	**Yes**	**No**
	Very cautious/afraid to try new things	**Yes**	**No**
	Nearly impossible to take to the movies, church/temple or other settings that don't allow them to move around	**Yes**	**No**
	Jump off tall furniture, take climbing risks	**Yes**	**No**
	Have trouble keeping personal space neat/organized (desk, drawers, room)	**Yes**	**No**
Comments:			

Dear Parents,

Please be advised that an evaluation is required prior to treatment. The fee for the evaluation is based on the time it takes for the therapist to evaluate and develop a written report and treatment plan. If you wish to bill your insurance company, a prescription from your pediatrician is needed prior to setting up an appointment for an evaluation. Although a prescription is not required by law, most insurance companies require it before processing or paying out the claim.

I have read and fully understand the above statement.

Parent's Signature Child's Name Date

ATTENDANCE POLICY

I agree to give at least **24 hours** notice when cancelling a set appointment. I will make an effort to re-schedule the appointment depending upon availability. In the event that I do not give this advanced notice, I agree to pay a $25.00 surcharge or cancellation fee. In the case of an emergency ONLY, I will notify SENSATION STATION as soon as possible and make arrangements to reschedule to appointment.

If 50% of set appointments are missed in any given month, I forfeit my standing appointments and I will have to call weekly in order to schedule my appointment. If 75% of set appointments are missed in any given month, dismissal from therapy mayl result.

I further acknowledge that if I arrive late for my scheduled appointment time, SENSATION STATION may not be able to accommodate the total treatment time and charges for the pre-scheduled therapy time will be billed in full. We realize that circumstances beyond our control do come up at times, and would like to establish a solid relationship with your child.

I have read and fully understand the above statement.

Parent's Signature Child's Name Date

PAYMENT POLICY

Payment for therapy and educational services provided will be due **upon receipt** of service. If payment cannot be made within **5** business days, SENSATION STATION must be contacted so that arrangements can be made. Failure to do so within **10** business days will result in suspension of therapy or educational services immediately as per our policy.

I have read and fully understand the above statement.

Parent's Signature Child's Name Date

ASSIGNMENT AND RELEASE

(Must be signed for evaluation and therapy to begin)

I, the undersigned, certify that I (or my dependent) have insurance coverage with (fill in company name):
and assign all insurance benefits **(*if applicable)*** directly to **SENSATION STATION GUILFORD INC** **I understand that I am financially responsible for all charges incurred whether or not I am using my insurance coverage and/or what is not paid for by my insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize the use of this signature to release medical records to primary physician and or Health Insurance Company.

Responsible Party's Signature	
Relationship	
Date	