Therapeutic Connections

9000 Sheridan Street
Pembroke Pines, FL 33024
(954) 680-1983

yourtherapyteam.com

INITIAL INTAKE FORM OCCUPATIONAL THERAPY

PATIENT INFORMATION

Patient Name	
Date of Birth	
Gender	
Parent / Guardian Name	
Address	
City, State, Zip	
Home Phone	
Cell Phone	
Email Address	
Dr. Name and Phone number	
Language(s) Spoken In Home	

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.	

PRENATAL / BIRTH HISTORY

History of pregnancy (i.e. medication, health of mother, complications):			
Present Maternal Age			
Number of previous pregnancies			
Ages of children			
Length of pregnancy	Full Term		Weeks Gestation
	Premature		Weeks Gestation
Type of delivery	Vaginal	C-Section	Breech

DEVELOPMENTAL HISTORY

Present level of activity	Active	Typical	Low Arousal
Developmental milestones (give approximate ages)	Sat alone	Crawling	Walking
	Running	Babbling	First Words
	Sentences	Dressing Self	Holds Bottle
	Uses Utensils	Cup Drinking	Uses Straw
	Finger Feeds	Hand Dominance	

MEDICAL HISTORY

List past/present medications	
List significant illnesses and infections (give approximate dates):	
List surgeries and hospitalizations (give approximate dates):	

List any allergies (food and nonfood)	
Did / does your child suffer from frequent ear infections? If yes, list number since birth.	

EDUCATIONAL BACKGROUND

Name of School	
Grade	
School Phone	
Teacher's Name	
Academic Concerns	

SENSORIMOTOR HISTORY

The following questions are utilized as a tool in order to compile a more complete picture of your child from early infancy to his/her present developmental stage. Some of these questions may refer to children who are older than your own. Circle/ highlight the choice that applies: (**Yes, No).** Add narrative information if necessary. Thank you.

TACTILE (TOUCH)

	Constantly touch objects or intrude in others personal space?	Yes	No
	Seems easily irritated or annoyed?	Yes	No
	Pinch, bite or otherwise hurt him/herself or others?	Yes	No
	Frequently bumps or pushes others?	Yes	No
	Doesn't cry when seriously hurt?	Yes	No
	Dislikes the feeling of fuzzy/furry clothing/textures?	Yes	No
	Seem overly sensitive to rough food textures?	Yes	No
	Dislike having hair washed/ cut or nails cut?	Yes	No
	Dislike the feeling of sand, mud, and clay on hands/feet?	Yes	No

VESTIBULAR (MOVEMENT)

Does child…	Like rough housing, jumping, crashing games?	Yes	No
	Like fast spinning carnival rides?	Yes	No
	Play on swings or slides?	Yes	No
	Get nauseous and/or vomit easily?	Yes	No
	Have fear in space (stairs, heights)?	Yes	No
	Lose balance easily?	Yes	No
	Walks on toe (not flat feet)?	Yes	No
	Prefer to be sedentary (on computer/ TV) than play outside?	Yes	No

VISUAL

Does child…	Have a diagnosed vision problem?	Yes	No
	Have trouble tracking objects with eyes?	Yes	No
	Avoid eye contact with others?	Yes	No
	Have trouble copying words from the board?	Yes	No
	Make reversals when copying or reading?	Yes	No
	Have trouble discriminating shapes, colors correctly?	Yes	No

TASTE & SMELL

Does child…	Chew on non-food items (pencils, shirt, hair)?	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

AUDITORY (SOUND)

Does 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/bother by loud sounds (school bells, sirens)?	Yes	No
	Respond negatively to unexpected noises?	Yes	No
	Fail to listen, or pay attention to what is said to him/her?	Yes	No
	Have a delay in speech development?	Yes	No

	Have difficultly if 2 or 3 steps instructions are given at once?	Yes	No
	Talk excessively/ not wait their turn?	Yes	No

MUSCLE TONE

Does child…	Big for his/her age?	Yes	No
	Slouch when sitting on floor/chair?	Yes	No
	Get tired easily playing or writing?	Yes	No

COORDINATION

Does child…	Sit, stand or walk late?	Yes	No
	Was creeping and crawling phase unusually prolonged?	Yes	No
	Was creeping and crawling phase almost entirely omitted?	Yes	No
	Have difficulty with sequential tasks; dressing, buttoning, zipping?	Yes	No
	Have difficulty playing on playground equipment?	Yes	No
	Have difficulty learning to hold a pencil or crayon in a 3-point position?	Yes	No
	Have poor ball skills for P.E. type activities?	Yes	No
	Seem clumsy, awkward?	Yes	No
	Consistently use a dominant hand?	Yes	No
	If yes, which hand?	Right	Left
	Have poor handwriting?	Yes	No
	Have trouble using both hands together easily (opening milk carton, water bottle etc.)?	Yes	No
	Enjoy sports, gym, etc?	Yes	No
	Able to ride a bike (tricycle, big wheel)?	Yes	No
	Able to tie shoelaces?	Yes	No

BEHAVIOR/TEMPERAMENT

Is child..	Quiet, calm, relaxed, patient?	Yes	No
	Active, outgoing, enthusiastic**?**	Yes	No
	Seem hyperactive, in perpetual motion all the time?	Yes	No
	Upset by transitions/unexpected changes?	Yes	No
	Have trouble keeping personal space neat/organized (desk, room)?	Yes	No

	Rigid, set in his/her ways?	Yes	No
	Jump off tall furniture, climbs trees without regard to safety	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

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 required 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 canceling a set appointment. In the event that I do not give this advanced notice, I agree to pay a 50% surcharge based on the set fee for therapy time scheduled. In the case of an emergency ONLY, I will notify Therapeutic Connections as soon as possible and make arrangements to reschedule the appointment. If 75% of set appointments are missed in any given month, dismissal from therapy will result.

I further acknowledge that if I arrive late for my scheduled appointment time, Therapeutic Connections may not be able to accommodate the total treatment time and charges for 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.

_____

Parent's Signature Child's Name Date

PAYMENT POLICY

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

I have read and fully understand and will comply with above statements.

_____

Parent's Signature Child's Name Date

I consent that I am the legal guardian/parent of the identified patient and that I have the right to independently seek medical/ psychological treatment for this child. If there is another party who needs to agree I certify that I have notified that party and that they agree to treatment.

_____

Parent signature /Date

HIPPA CONSENT:

This form is between you and this practice. When we use the word "you" below, it can mean you, your child, a relative or other person if you have written his/her name here _____. Your signature here certifies your consent that we may use/share your protected Health Information, as described in the HIPPA PRIVACY NOTICE.

_____

Parent signature/ 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 **O.T. BY RONI CASSER**, DBA **Therapeutic Connections** **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	