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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 understand that, unless otherwise required by state law, benefits given is not a guarantee of payment. Benefits are subject to all contract limits and the member’s status on the date of service. Accumulated amounts may change as additional claims are processed.**  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 |  |