**SPEECH THERAPY ON THE GO INC.**

**OCCUPATIONAL THERAPY INITIAL INTAKE FORM**

**PATIENT INFORMATION**

|  |  |
| --- | --- |
| Patient Name |  |
| Date of Birth |  |
| Gender |  |
| Parent / Guardian Name |  |
| Address |  |
| City, State, Zip |  |
| Home Phone |  |
| Cell Phone |  |
| Email Address  |  |
| Daytime Caregivers Name |  |
| Language(s) Spoken In Home |  |
| Days, times and location of therapy |  |

**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 (e.g., mental deficits, learning deficits, cerebral palsy) |  |

**PRENATAL / BIRTH HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| History of pregnancy (i.e. medication, health of mother, complications): |  |  |  |  |
| Maternal Age |  |  |  |  |
| Number of previous pregnancies |  |  |  |  |
| Number of children |  |  |  |  |
| Ages of children |  |  |  |  |
| Length of pregnancy |  |  |  |  |
|  |  |  |  |  |
| Type of delivery |  |  |  |  |
| Note complications of labor / delivery, including medications |  |  |  |  |
| Birth weight |  |  |  |  |
| Length of hospital stay |  |  |  |  |
| Did / does your child have difficulty… |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

## DEVELOPMENTAL HISTORY

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

## 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 Address  |  |
| School City, State, Zip |  |
| School Phone |  |
| Teacher’s Name |  |
| Academic Concerns |  |

**FUNCTIONAL STATUS**

|  |  |
| --- | --- |
| Self Care |  |
| Visual Perceptual |  |
| Fine Motor |  |
| Gross Motor |  |
| Social / Emotional |  |
| Cognition |  |
| Language |  |
| Attention / Concentration |  |

**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. Kindly cross out the verb tense that does not apply. Circle the choice that applies: (**Yes, No).** Add narrative information if necessary. Thank you for your cooperation.

Please think of the various stages of your child’s development, taking into considering behaviors as you answer the questions below. What do you think of as being different from other children you know? Are there times when his/her behavior is difficult to cope within the family unit?

**CHILD’S BIRTH**

|  |  |  |  |
| --- | --- | --- | --- |
| Was or did child... | Full term? | Yes  | No |
|  | Premature? | Yes | No  |
|  | Cesarean section? | Yes | No  |
|  | Breech (feet first)? | Yes | No  |
|  | Cord around neck? | Yes | No  |
|  | Require forceps? | Yes | No  |
|  | Have sufficient oxygen? | Yes  | No |
|  | Require ICU hospitalization? | Yes | No  |
|  | If yes, how long? |  |  |
|  | Have respiratory problems? | Yes | No  |
|  | Need a respirator? | Yes | No  |
|  | If yes, how long? |  |  |
|  | Small for gestational age? | Yes | No  |
|  | Have a heart defect? | Yes | No  |
|  | Have jaundice? | Yes | No  |
|  | If yes, how long? |  |  |
|  | Have congenital abnormalities? | Yes | No  |
|  | Have seizures? | Yes | No  |
|  | Have infections? | Yes | No  |
|  | If yes, type of infections? |  |  |
|  | Have surgery as newborn? Circumcision | Yes  | No |
|  | Have feeding problems as a newborn? | Yes | No  |
| Comments: |  |  |  |

**TACTILE (TOUCH)**

|  |  |  |  |
| --- | --- | --- | --- |
| Does child… | Dislike being held or cuddled? | Yes | No  |
|  | Constantly touch objects or intrude in others personal space? | Yes  | No |
|  | Seems easily irritated or enraged? | Yes | No  |
|  | Have a strong need to touch objects and people? | Yes  | No |
|  | Pinch, bite or otherwise hurt him/herself or others? | Yes  | No |
|  | Frequently bumps or pushes others? When they take his toys | Yes  | No |
|  | Doesn’t cry when seriously hurt? | Yes | No  |
|  | Dislikes the feeling of fuzzy/furry clothing/textures? | Yes  | No |
|  | Over or under dresses for the temperature? | 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  |
|  | Often seems unaware of minor cuts, bruises, etc? | Yes | No  |
|  | Seem unaware of food/liquid left on lips? | Yes | No  |
|  | Tell what is in his/her hand without looking? | Yes | No |
| Comments: |  |  |  |

**VESTIBULAR (MOVEMENT)**

|  |  |  |  |
| --- | --- | --- | --- |
| Does child… | Like rough housing, jumping, crashing games? Dislikes bouncy houses and birthday gyms | Yes  | No  |
|  | Like being tossed in the air? Only like open bouncy houses with few kids, or his individual trampolin | Yes  | No |
|  | Like fast spinning carnival rides? | Yes  | No |
|  | Play on swings or slides? | Yes  | No |
|  | Spin or whirls more than other children? | Yes | No  |
|  | Get carsick easily? | 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  |
|  | Like being upside down (somersaults, hanging from legs? N/A | Yes | No |
|  | Prefer to be sedentary (on computer/ TV) than play outside? | Yes | No  |
| Comments: |  |  |  |

**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? N/A | Yes | No |
|  | Dislike having eyes covered? He actually likes having a mask to sleep like mommy | Yes | No  |
|  | Make reversals when copying or reading? N/A | Yes | No |
|  | Have trouble discriminating shapes, colors correctly? | Yes | No  |
|  | Squint often (when reading or outside in sunlight)? | Yes | No |
| Comments: |  |  |  |

**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 |
|  | Prefer spicy, sour bitter food flavors? | Yes | No  |
| Comments: |  |  |  |

**AUDITORY (SOUND)**

|  |  |  |  |
| --- | --- | --- | --- |
| Does child… | Have a diagnosed hearing problem? Used to | Yes | No  |
|  | Have PE tubes in his/her ears? | Yes  | No |
|  | Have frequent ear infections? Used to  | Yes | No  |
|  | Show difficulty/bother by loud sounds (school bells, sirens)? After surgery | Yes  | No |
|  | Respond negatively to unexpected noises? | Yes  | No |
|  | Show bother by back ground sounds such as refrigerator, fluorescent light bulbs, fans, when trying to concentrate? | Yes | No  |
|  | Fail to listen, or pay attention to what is said to him/her? | Yes | No  |
|  | Like to play or make music at loud volumes? | Yes  | No |
|  | Like to sing and/or dance to music? | Yes  | No |
|  | Have difficultly if 2 or 3 steps instructions are given at once? | Yes  | No |
|  | Talk excessively/ not wait their turn?  | Yes | No  |
|  | Have a delay in speech development? | Yes  | No |
| Comments |  |  |  |

**MUSCLE TONE**

|  |  |  |  |
| --- | --- | --- | --- |
| Does child… | Big for his/her age? | Yes  | No |
|  | Have any diagnosed muscle problems? | Yes | No  |
|  | Have flat feet? | Yes | No  |
|  | Slouch when sitting on floor/chair? | Yes | No  |
|  | Get tired easily playing or writing? | Yes | No  |
|  | Seem generally weak compared to other kids? | Yes | No  |
|  | Keep mouth open when breathing? | Yes | No  |
| Comments |  |  |  |

**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? N/A, he is not yet dressing completely by himself. | 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  |
|  | Bump into furniture, people a lot? | Yes  | No  |
|  | Consistently use a dominant hand? Not yet | Yes | No  |
|  |  If yes, which hand? | Right | Left |
|  | Have poor handwriting? N/A | Yes | No |
|  | Have trouble using both hands together easily (opening milk carton, water bottle etc.)? | Yes | No  |
|  | Enjoy sports, gym, etc? enjoy sports, but not closed gyms | Yes  | No |
|  | Able to ride a bike (tricycle, big wheel)? | Yes  | No |
|  | Able to tie shoelaces? N/A | Yes | No  |
| Comments: |  |  |  |

# **BEHAVIOR/TEMPERAMENT**

|  |  |  |  |
| --- | --- | --- | --- |
| Is child… | Quiet, calm, relaxed, patient? For the most part… if not tired or hungry | Yes  | No |
|  | Active, outgoing, enthusiastic**?** | Yes  | No |
|  | Intense, demanding? | Yes  | No |
|  | Seem hyperactive, in perpetual motion all the time? | Yes | No  |
|  | Upset by transitions/unexpected changes? He has been very flexible when traveling out of the country | Yes | No  |
|  | 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, climbs trees without regard to safety N/A | Yes | No |
|  | Have trouble keeping personal space neat/organized (desk, room)? N/A | 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 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 Speech Therapy on the Go Inc. 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, Speech Therapy on the Go Inc. 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, Speech Therapy on the Go Inc. 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

**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 **Amanda Foutch** doing business as **Speech Therapy on the Go 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 |   |