FUNctional Kids Therapy Center LLC

Outpatient Pediatric Intake Form

Child's name: ___________________________________ DOB: __________ Age: _______ M/F: __________
Current Diagnosis: ____
Street:_____________________________ City:________________ State: ____ Zip Code: _______________ Home Phone: ____________________ Preferred E-mail Address: ____________________________________

School Attended: ____ Grade: ___________

Parent #1 name: ____________________________________ Occupation: ___________________________ Home Phone: ___________________ Cell Phone: _____________________ Work Phone: _______________
Parent #2 name: ____________________________________ Occupation: ___________________________
Home Phone: ___________________ Cell Phone: _____________________ Work Phone: _______________
Siblings that live in the home (gender and age)____
Emergency Contact: ___________________ Relationship: _________________ Phone: _________________
Primary Language: __________________________ Language Spoken at Home: ________________________

Child's Primary Physician: ______________________________ Address/Phone: _____________________ Child's Referring Physician: ______________________________ Address/Phone: ______________________ Reason for Referral: ____

What are your primary areas of concern/What are you hoping for the Occupational/Speech Therapist to address?
____
____
____
____ _____

What are your goals for Occupational/Speech Therapy?
____
____
____
____ ______

Please list any Medical Precautions/Allergies/Medications
____
____
____
____

Has your child's hearing been evaluated recently? (If yes, when, by whom, and what were the results?)
____
____
____
____

Is your child receiving any other services (i.e. Speech, Physical Therapy, Special Education, Early Intervention)?
____
____
____
____ _________

What (if any) special equipment does your child use?
Wheelchair: _____ Eye glasses: _____ Hearing Aids: _____ Braces: _____ Walker: _____

Communication Device: _____ Crutches: _____ Other: _____

Prenatal & Birth History:

Please list any significant prenatal or birth history (weeks gestation, birth weight, APGARS):
____
____
____
____

___Premature ___Full term ___Low birth weight ___Weeks Gestation ___Breech Birth ___C-section
___Emergency C-section ___Vaginal Birth ___Forceps Delivery ___Vacuum Delivery ___Preeclampsia
___Gestational Diabetes ___Breast fed ___Poor suction/latch ___Bottle fed ___Multiple Ultrasounds
___Oxygen at Birth ___NICU stay ___Duration in NICU____ ___ Jaundice: _______ Other:_____________

Medical History:

Please list any significant illness, hospitalizations, etc... :
____
____
____
____

___Chronic ear infections ___Tubes ___Tonsils/Adenoid Surgery ___Reflux ___Surgeries: list above ___Poor weight gain

Developmental History:

___Colic ___Poor sleep ___Asthma ___Abnormal muscle tone ___Torticollis ___Asthma ___ Cardiac Issues
___Frequent antibiotic use ___Frequent fevers ___Compromised immune system ___Abnormal Lab results

Circle statement that best describes your child:

Didn't like tummy time or not placed much on belly OR Loved being on belly
Met all motor milestones on time OR Was/is developmentally delayed
Is clumsy OR Has always seemed athletic Struggles with use of hands/fine motor OR Uses utensils and pencils easily Avoids climbing, swinging, being upside down OR Seems to crave/love movement

When did your child do the following:

Skill	Age Skill Developed (months)
Sat up:	
Rolled over:	
Pulled up to stand:	
Belly crawled:	
Hands and Knees Crawling:	

Walking:	
Began Babbling	
Spoke First Word:	
Short Phrases:	
Spoke in Sentences:	

My child communicates using:
___ is non-verbal
___ single words
___ 2-3 word phrases
___ sentences

Please list any motor development concerns you have (i.e. gross motor, fine motor, oral motor, motor planning, fear of movement, fear of heights, etc...):
____
____
____

Academic History:

Does your child attend school? ____ If so, where? ________________________________Grade:________________________
Does your child have an IFS/IEP? __________

Check off all that apply to your child:
___Does well in school

___Does well with the exception of: ___________________________ ___Is challenged by school
___Is challenged by writing
___Is challenged by reading comprehension
___is challenged by decoding

___Is not enrolled in school
___Receives resource/ tutoring for: ____________________________ ___Isan A B C D F Student
___Is in a self-contained classroom

Please list any academic concerns you have:
____
____
____

Please list any specific teacher concerns:
____
____
____

Behavior/Social History:

Check off all that apply to your child
___Is social and engaging
___Makes good eye contact with adults and peers ___Is well behaved
___Pays attention
___Listens well
___Follows directions well
___Plays well with other children
___Is easy going
___Does well with change
___Understands safety
___Takes turns with peers
___Is aggressive ___Is oppositional

___Does not like new places/ people ___Does not like crowds
___Has difficulty with transitions ___Prefers to play alone

___Has difficulty paying attention ___Has difficulty listening
___Is very busy and active ___Poor coping skills

___Unable to self-calm
___Extremely sensitive to criticism ___Quickly escalates without apparent cause ___Has tantrums

Please list any behavioral or social concerns:
____
____
____

Evaluation & Therapy Services:

Please list any previous occupational/speech therapy evaluations completed and recommendations:
____
____
____

Please list any previous psychological/neuropsychological/psych-educational evaluations completed and recommendations:
____
____
____

Please read and check the statement that best describes your interest in alternative health training/use

☐ **I AM** interested in learning about natural healthy ways to optimize my child's learning (essential oils, nutritional supplements or nutritional assessment or dietary changes)

☐ Please DO NOT discuss or use alternative methods of intervention with my child or discuss it in session. Thank you!

*Please note that YOU are responsible for knowing your co-insurance, co-pay and deductible amounts. Functional Kids is NOT responsible for these costs that are dictated/outlined by your insurance carrier.

****Should you be delinquent in paying your bill past 3 months and have not made arrangements for a payment schedule, you are legally responsible for the amount outlined by your insurance carrier and will be sent to collections if account goes unpaid. You are responsible for any fees Functional Kids Therapy Center LLC incurs in collecting therapy service fees from you including legal costs for actions that may be needed to collect on your account(s).**

My signature below is confirmation that I have informed FUNctional Kids Therapy Center LLC of all necessary information and have answered all questions truthfully and to the best of my ability.

____ ____________________
Parent signature Date

FUNctional Kids Attendance Policy

FUNctional Kids Therapy Center wants to improve you and your child's quality of life through consistent and high quality care. Cancellations, especially those with less than 24 hour notice including no-call/no-shows limit your child's progress and our ability to care for others. Please call the main line at: (269) 223-7789.We ask for your full cooperation with the following policy:

- If you are unable to keep your scheduled appointment, we request that you notify us immediately so that your appointment can be rescheduled and another patient may take your slot.**24 hours or greater notice is required to do this.**

- All cancellations and no-shows will be documented in your medical record and appropriately reported to your Physician and Insurance/Third Party Payer.

- <u>If you accumulate 2no-shows this will result in automatic discharge and physician notification</u>

- Greater than 50% cancellation in a 30 day period will also result in loss of preferred afternoon or early morning time slot(s) until further consistent attendance is established.

We believe that this policy is necessary for the benefit of all patients, so that we can continue to provide high-quality treatment and service to everyone.

If you should have any questions regarding this policy, please feel free to discuss them with your therapist.

Patient Signature:____Date:

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for**FUNctional Kids Therapy Center** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **FUNctional Kids Therapy Center** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **FUNctional Kids Therapy Center** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by written request.

With this consent, **FUNctional Kids Therapy Center** may call my home or other alternativelocation and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

With this consent, **FUNctional Kids Therapy Center** may mail to my home or other alternativelocation any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **FUNctional Kids Therapy Center** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **FUNctional Kids Therapy Center** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **FUNCtional Kids Therapy Center** to use and disclose my PHI to carry out TPO with health care providers including doctors, therapists and other health care professions. Please list below specialists below:

____

Patient Signature:____ Date:____________

Additional Consent

I, _________________________________ consent to the use of video/photos of myself or my child to assist in training professionals and providing comprehensive care for my child.

I, __________________________________ consent to allowing the interaction between my child and other children in the therapy center during therapy appointments. I understand this consent is for therapeutic purposes and my demographic/personal information will not be shared with other families unless specifically authorized.