PATIENT INTAKE

Childs name:________________________________ Gender(M or F) DOB:__________

Childs Address:_______________________________________ City:_____ State:_____

Zipcode:________

Caregiver name:_______________________________ Relationship:________________

Caregiver Drivers License#___________________ Email:_________________________

Cell Phone number:_______________________ Work number :______________________

Other Caregiver name:__________________________ Relationship:________________

Caregiver Drivers License#___________________ Email:_________________________

Cell Phone number:_______________________ Work number :______________________

Other Contact (If caregiver unavailable):_______________________________

Relationship:________________________

Cell Phone number:_______________________ Work number :______________________

REFERRAL INFORMATION

Referring physician:______________________ Phone number:____________________

Address:_________________________________ Fax number:_______________________

Reason for referral (diagnosis,concerns):

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INSURANCE INFORMATION

Primary Insurance Co:____

PrimarySubscriber:______________________________SubscriberID#:_______________

Primary DOB:________________ Group Number:_________________________________

MEDICAL AND DEVELOPMENTAL HISTORY

Please list childs allergies:

____

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Does your child have or have they had any of the following medical issues?

Please circle all that apply: Hearing difficulties, Visual difficulties, Swallowing difficulties, Asthma, Respiratory Difficulties, Seizures, Ear infections, Cardiac conditions.

Provide information on medical conditions circled above and any not listed:____

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PREGNANCY AND DELIVERY

Pregnancy term: ____________ Any complications?_________________________________

Delivered: Vaginally or C Section (please circle one)

Did child experience any difficulties at birth? Respiratory, Cardiac, feeding, Jaundice (circle all that apply). Other:____

DEVELOPMENTAL HISTORY

At what age did child achieve developmental milestones? Please write months or age child acquired the following skills, if milestone not yet achieved; write N/A:

Rolled over____________Sat alone____________ Crawled_______________
Walked_____________ Spoke first words________ Self fed (fingers)___________

Potty trained_____

PARENTAL CONCERNS

What are your concerns regarding your child? (i.e. fine motor skills, attention, behavioral difficulties, speech skills, feeding, sensory processing

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SCHOOLING

Is your child in school: (Y or N) School Name:____________________________________
Grade:___________________Classroom setting/accomodations/IEP:____________________

CHILDS LIKES AND DISLIKES (Please list objects, toys, games, etc that your child enjoys and those that he dislikes; this will help us to successfully engage with your child).

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Parent or Guardian Signature____________________________ Date__________________