1-800-971-7970

OCCUPATIONAL THERAPY PEDIATRIC INTAKE FORM
NEW PATIENT INFORMATION

DATE: ______________________________

PATIENT: ____ DOB: _____________________________

AGE: _________________ SEX: ☐ FEMALE ☐ MALE

ADDRESS: ____

CITY /STATE/ ZIP:
____

PHYSICIAN: __________________________________ SPECIALIST: _________________________________

SPECIALIST:__________________________________ SPECIALIST:__________________________________

WHO MAY WE THANK FOR THIS REFERRAL? ____
PERSON COMPLETING FORM: _____________________________ RELATIONSHIP: ___________________

FAMILY INFORMATION:

MOM'S NAME:____

MOM'S PRIMARY PHONE NUMBER:(___)___________ MOM'S SECONDARY PHONE:(___)____________

DOES MOM LIVE WITH CHILD? ☐ YES ☐ NO

DAD'S NAME:____

DAD'S PRIMARY PHONE NUMBER:(___)_____________DAD'S SECONDARY PHONE:(___)_____________

DOES DAD LIVE WITH CHILD? ☐ YES ☐ NO

LANGUAGE(S) SPOKEN IN THE HOME: ____

NAMES AND AGES OF SIBLNGS: ____

____

NAMES AND AGES OF ANY OTHERS LIVING IN THE HOME:_______________________________________

____

TYPES OF PETS IN THE HOME: ____

EMERGENCY INFORMATION SHEET: (2013-2014)

Child: ___________________________________ Birth date:_____________ Phone:(___)____________

Address:____Zip:_________________

Email:____

Parent Name (1): ____________________________Work Phone:(____)__________Cell:_____________

Parent Name (2): ____________________________Work Phone:(____)__________Cell:_____________

Caregiver's Name: ____ Phone :(____)__________________

Child's School:____ School Phone:(____)________________

Two persons to call if we cannot reach parents/caregiver in an emergency:
Name: ______________________________ Relationship: ______________ Phone :(___)______________

Name: ______________________________ Relationship: ______________ Phone :(___)______________

Child's Doctor :____ Phone: (___)______________

Conditions Which May Require Immediate or Emergency Care (i.e., diabetes, epilepsy, bee sting reactions, allergies, etc.)
1. __________________________________ Treatment:____
2. __________________________________Treatment: ____
3. __________________________________Treatment: ____

If your child is taking medication on a regular basis, please indicate name of the medication and the purpose of the medication as well as any other pertinent information below:
1.) ____ 2.)____
3.) ____ 4.)____
5.) ____ 6.)____

Please list any and all allergies your child has (food, latex..etc.):___________________________________
____
Does your child wear glasses/corrective lenses? _________________________________

If my child becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or above-named physician to give the emergency medical treatment required:

Hospital: _____________________________ Address: ____

Parents Signature:_______________________________________ Date:___________________________

PATIENT HISTORY QUESTIONAIRE

Please indicate whether or not your child has received any of the following therapies in the past year:

YES	NO		Date of last evaluation	Therapy provider
☐	☐	Occupational therapy	____________________	_______________________
☐	☐	Speech/language therapy	____________________	_______________________
☐	☐	Physical therapy	____________________	_______________________
☐	☐	Nutrition therapy	____________________	_______________________
☐	☐	Psychological/behavioral/counseling	_____________________	_______________________

DIAGNOSIS (check all that apply):

☐ Autism spectrum disorder ☐ Asperger's syndrome ☐ Cerebral palsy

☐ ADD/ ADHD (Attention Deficit Disorder) ☐ Cognitive delay ☐ Down syndrome

☐ Pervasive Developmental Disorder ☐ Learning disability ☐ Genetic disorder

☐ Sensory processing disorder or sensory integration dysfunction ☐ Fragile X syndrome

☐ Anxiety or mood disorder(s) Specify: ____

☐ Emotional disorder Specify: ____

☐ Other Specify: ____

Please note who provided the above diagnosis and what criteria that diagnosis was based on (i.e.: test scores, comprehensive clinical evaluation, genetic study, etc.):

____

____

____

COMMENTS:

____

____

____

Caregiver Goals (In your own words, please describe why you are bringing your child for therapy and what you would like to have happen):

____

____

Hand Dominance: ☐ Right ☐ Left ☐ Not Sure

Does your child stay home during the day? If so, with whom do they stay? _______________________

____

Does your child attend daycare or school? If so, which facility and grade does your child attend?

____

What concerns do you have regarding your child at school?

____

____

List concerns your child's teacher/daycare provider have beginning with those of greatest importance:

____

____

What solutions have been attempted at home and at school?

____

____

Does your child receive any special education services at school? _______________________________

Does your child have an IEP/IFSP? ☐ Yes ☐ No

What are your child's gifts/strengths?

____

____

What do you enjoy most about your child and family?

____

____

What kind of interests and activities does your child enjoy? (i.e.: hobbies, sports, clubs, etc.) Please list them in order of preference beginning with the favorite interest/activity.

____

____

Does your child have any behavioral issues about which you are concerned? If yes, please explain.

____

____

Does your child have any self-injurious behavior such as hitting her/his head or biting her/himself?

____

____

Does your child ever lash out at others physically when frustrated or at any other time?

____
____

What disciplinary techniques have you been using with your child? Do you feel they are effective?

____
____

Does your child have any specific fears of which we should be aware?

____
____

How would you describe your child's general adjustment at home? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

How would you describe your child's relationship with the following family members:

Mother:____

Father:____

Guardian:____

Sibling(s):____

Have there been any significant family events in the course of this child's development, such as extended separations, abuses, major moves, divorce, marriage, or birth of sibling(s)?

____
____

PRENATAL HISTORY:PREGNANCY

(If child is adopted, please give what information you have and/or skip to Adoption History section)

Mother's condition during pregnancy included:

☐ Do not know ☐ In good general health ☐ Physically active
☐ Anemia ☐ Bleeding ☐ Toxemia
☐ Premature contractions ☐ Confinement to bed ☐ Edema (swelling)
☐ Hypertension (high blood pressure) ☐ Cardiac infection ☐ Rubella
☐ Gestational diabetes ☐ Convulsions ☐ Serious injury
☐ Viral infection ☐ High fever ☐ Surgery
☐ Excessive nausea ☐ Amniotic fluid loss ☐ Shock
☐ Drank alcohol frequently ☐ Drank alcohol infrequently ☐ Drank no alcohol
☐ Smoked more than one pack a day ☐ Smoked less than one pack a day ☐ Did not smoke
☐ Emotional strain ☐ Stress ☐ Loss of loved one
☐ Exposed to loud noises ☐ Accident ☐ Allergies
☐ Used prescription drugs List: ____
☐ Used illegal drugs List: ____

Were fertility treatments used to achieve pregnancy? ______________________________

Was this a multiple birth? Birth order? ______________________________________

Any previous complicated pregnancies? _______________________________________

COMMENTS:

____

____

POSNATAL HISTORY: LABOR AND DELIVERY

Length of labor ____________ hours

Birth weight ____ pounds ____ ounces

Apgar ratings (if known): __________ _________ _________

Delivery position (i.e.: breech, etc.) ____

INDICATE THE CHARACTERISTICS OF THE LABOR AND DELIVERY:

- ☐ Information not available
- ☐ Typical, no problems
- ☐ Full term, 38+ weeks
- ☐ Premature
- _________-weeks gestation
- ☐ Spontaneous labor
- ☐ Induced labor
- ☐ Normal vaginal delivery
- ☐ Forceps used
- ☐ Suction/Vacuum used
- ☐ Cord around neck
- ☐ Jaundice
- ☐ C-section
- ☐ Emergency
- ☐ Scheduled
- ☐ Local anesthesia-epidural
- ☐ General anesthesia-unconscious
- ☐ RH factor problems
- ☐ Blood transfusion
- ☐ Low birth weight
- ☐ Infant limp/floppy
- ☐ Baby cried immediately
- ☐ Did not immediately breathe
- ☐ Slow heartbeat
- ☐ Poor sucking
- ☐ Feeding tube
- ☐ Brachial plexus injury
- ☐ Immediate newborn/mother contact
- ☐ Separation in first days

POSTNATAL HISTORY: ADOPTION

Describe the circumstances surrounding the adoption:

Age when adopted: ____

Prior foster homes: ____

Physical appearance when adopted:_____________________________________

Response to new home: ____

Is child aware of her/his adoption? ______________________________________

Diagnosed with attachment problems? ____________________________________

Has child or family had psychological counseling? _________________________

COMMENTS:

____

____

____

____

INFANCY AND TODDLERHOOD

Check all problems that apply to your child and provide details:

- ☐ Information not available
- ☐ Breastfed
- ☐ Health problems (specify below)
- ☐ Extended separations (over three days)
- ☐ Feeding problems (specify below)
- ☐ Colic or fussiness
- ☐ Able to self soothe
- ☐ Disliked lying on stomach
- ☐ Disliked lying on back
- ☐ Had position preference as infant
- ☐ Ear infections
- ☐ Reflux
- ☐ Difficulty sucking
- ☐ Spits up frequently
- ☐ Wants to be held most of the time
- ☐ Does not want to be held
- ☐ Thumb sucking/pacifier (until what age)
- ☐ Chokes on food
- ☐ Food allergies (list below)
- ☐ Difficulty swallowing
- ☐ Refuses most food
- ☐ Poor appetite
- ☐ Dislikes certain foods/textures
- ☐ Daily activities on regular schedule
- ☐ Enjoyed bouncing
- ☐ Calmed by car rides/infant swings
- ☐ Nauseated by car rides/infant swings
- ☐ Difficult to comfort
- ☐ Extremely active
- ☐ Inactive, sluggish
- ☐ Inactive and quiet, but alert
- ☐ Difficulty falling asleep
- ☐ Excessive sleeper
- ☐ Sleeps little
- ☐ Physically active during sleep
- ☐ Often sleeps in parents' bed
- ☐ Needs a parent's presence to fall asleep
- ☐ Difficult to awaken
- ☐ Sleep walker
- ☐ Toe walked (until what age)
- ☐ Went through "Terrible Twos"
- ☐ Wanders from table when eating
- ☐ Reaches to be picked up
- ☐ Calm ☐ Playful ☐ Fearful
- ☐ Sociable ☐ Alert ☐ Happy
- ☐ Affectionate ☐ Angry ☐ Withdrawn

COMMENTS:

____
____
____

INFANCY AND TODDLERHOOD: continued

Please give approximate ages that your child:

Sat independently: _____________________ Crawled: _____________________________

Stood independently: ___________________ Walked independently: __________________

Put first words together: _________________ Said first words: _______________________

Could be understood: ___________________

Describe your child's toddler stage**:**

____
____
____

Describe the toilet training experience:

____
____

Age achieved during the day: ______________ Age achieved at night: _______________

CHILDHOOD ILLNESSES/PROBLEMS

Check all problems that apply to your child and provide details:

		AGE	COMMENTS
Ear infections (how many?)	☐	_____	______________________________
Pressure equalizing (PE) tubes in ears	☐	_____	______________________________
High fever	☐	_____	______________________________
Meningitis	☐	_____	______________________________
Adenoid problems	☐	_____	______________________________
Frequent colds	☐	_____	______________________________
Strep throat	☐	_____	______________________________
Allergies	☐	_____	______________________________
Immunizations	☐	_____	______________________________
Asthma/Bronchitis	☐	_____	______________________________
RSV	☐	_____	______________________________
Skin problems	☐	_____	______________________________
Gastro-intestinal problems	☐	_____	______________________________
Seizures/Epilepsy	☐	_____	______________________________
Sleep problems	☐	_____	______________________________
Nightmares/Night terrors	☐	_____	______________________________
Restless	☐	_____	______________________________
Wakes frequently	☐	_____	______________________________
Bedwetting	☐	_____	______________________________
Nail biting	☐	_____	______________________________
Broken limbs	☐	_____	______________________________
Other	☐	_____	______________________________

Has the child ever been hospitalized? ☐ Yes ☐ No

Reason: ____

Has the child ever had a serious accident/injury? ☐ Yes ☐ No

Explain: ____

Are there any other diagnosed medical illnesses/conditions? ☐ Yes ☐ No

List: ____

Is the child currently in good general health? ☐ Yes ☐ No

If no, please explain: ____

CONSENT TO TREATMENT/CONSENT TO RELEASE INFORMATION

I authorize the staff at Transformations Rehabilitation Services, occupational therapists as well as any support staff to provide care which they deem beneficial to myself or my child. Furthermore, I understand that Transformations Rehabilitation Services, has promised no specific outcomes as to the services provided at this facility.

X_________________________________ X_____________________________
Signature Patient Name

_________________________________ _____________________________
Relationship Date

_________________________________ _____________________________
Witness Date

*patient must be 18 years old or older to sign for their care

I authorize the occupational therapists and support staff of this facility consent to release any or all pertinent medical information to the referring physician and any additional physicians listed below to maintain quality of care. Furthermore, I authorize Transformations Rehabilitation Services, to release information to insurance providers to coordinate payment of benefits.

X_________________________________ X_____________________________
Signature Patient Name

_________________________________ _____________________________
Relationship Date

_________________________________ _____________________________
Witness Date

Additional physicians:

Name:______________________ Name:____________________
Address:___________________ Address:__________________
__________________________ ________________________
__________________________ ________________________
Phone:_____________________ Phone:____________________
Fax:_______________________ Fax:______________________

RELEASE FOR EDUCATIONAL AND TEACHING PURPOSES

I, _____________________________, authorize the therapists at Transformations Rehabilitation services, to allow my child, ___________________________, to be observed and or receive therapy during sessions by fieldwork students/interns and/or volunteers in our usual practice. I understand that these individuals will be signing confidentiality agreements as mandated by HIPAA and that any information will be used for teaching purposes only.

X____________________________________ _________________________
Parent/Guardian Signature Date

CANCELLATION POLICY

Transformation Rehabilitation Services, takes the care of our patients and their families very seriously. It is very important to us that you attend your regularly scheduled appointments. These scheduled appointments are part of a recommended treatment plan aimed at improving health, function, and the overall quality of life of our patients. Without regularly attending your scheduled appointments, the benefits of therapy will be limited. In addition, several children are waiting to receive therapy services during optimal times such as afternoons following school or in the evenings when parents are home from work. Due to the high number of individuals in need of these times, Transformations Rehabilitation Services, would like to make every effort to accommodate those in need and who are available to make their appointment times. We understand that families are busy and schedules are often difficult to manage. Families who are late for or cancel (without a excuses or doctors note) 3 therapy sessions in a row their treatment time, they will be contacted to be removed from the scheduled time. If more than 4 cancellations/no shows occur within a patient's recommended plan of care timeframe, Transformations Rehabilitation Services, will hold the right to recommend discontinuing therapy services. The patient will then be removed from their therapist's schedule to allow for other individuals to use this time slot.

X____ ____________________

Client/Guardian Signature Date

WAIVER OF H.I.P.A.A. LIABILITY

Due to federal guidelines protecting all private patient health information, Transformation Rehabilitation Services has a policy in place that prohibits discussion of all information regarding your child's assessment, treatment and care, in public areas such as the patient waiting room or in the open treatment clinic.

All discussion regarding your child/children will take place in a private room away from the general public.

By signing this waiver of H.I.P.A.A. liability, you as the parents or guardians, are releasing Transformation Rehabilitation Services from any harm or fault caused by discussing the private health information in such open access areas in our facility such as the waiting room area with you as the parent or a preferred guardian you send to accompany your child to their therapy sessions. This waiver is to encourage ongoing discussion between the therapist and family.
This waiver will be in place from the date signed below, until such a time that you as the parents and/or guardians request in writing to Transformation Rehabilitation Services that all discussion take place in a private setting.

X____ _________________________
Parent/Guardian Signature Date

Patients Insurance Information

Patient Name:___________________________ DOB:_________ SS#:______________

Address:____

Insured's or Sponsor's Name (if different then patients name):_______________________________________

Relation to patient: _________________SS#:______________ DOB:______________

Insured's or Sponsor's Address:____

Patient Relationship To Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:____________

Home Phone Number:(___)____________ Cell Phone Number:(___)_____________

Insurance:_____________________________________ ID#:____________________

Secondary Insurance:_______________________________ ID#:_________________

Financial Responsibility / Insurance Disclosure

I authorize Transformation Rehabilitation Services, to bill my insurance and receive direct payment from my primary insurance as well as my secondary insurance companies so that Transformation Rehabilitation Services, will be paid for the therapy services provided. Furthermore, I understand that I am financially responsible for any fees not paid
or covered by my insurance providers. I also acknowledge that I am responsible for co-pays, co-insurance and deductibles which are included as part of my insurance contracts. It is my responsibility to inquire and understand my insurance policy(s) and communicate with Transformation Rehabilitation Services when coverage changes occur.
By signing this form, I understand and agree that (regardless of insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.

____ ________________________
Patient Name Date

X_______________________________________ _________________________
Signature Relationship

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about the patient may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Responsibilities:
We are required by law to maintain the privacy of your health information and provide you with a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures:
The following categories describe how we may use and disclose your medical information.

For Treatment:
We may use health information about you to provide you treatment or services. This means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

For Payment:
We may use and disclose health information about your treatment and services for such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

For Health Care Operations:
Members of our staff may use information in your health record for the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may disclose information to students for educational purposes. We may remove information that identifies you from this set of health information to protect your privacy. We may contact you to remind you that you have an appointment; assess your satisfaction with our services; tell you about possible treatment alternatives; tell you about health-related benefits or services;
and we may leave messages on your answering machine or voice mail regarding primary appointment reminders and billing/collections efforts.

Future Communications:
We may contact you in the future via newsletters, mail outs, or other means regarding treatment options, health related information, or other community based initiatives or activities our facility is participating in.

Organized Health Care Arrangement:
This facility and its staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment, and healthcare operations. Therapists and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Law Enforcement/Legal Proceedings:

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Your Health Information Rights:
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

Inspect and Copy:
You have the right to inspect and obtain a copy of your health information, including billing records.

Amend:
If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our facility. Any request for an amendment must be sent in writing to the Facility Privacy Official.

An Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment, or healthcare operations where an authorization was not required.

Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care (i.e., family member or friend). Any request for a restriction must be sent in writing to the Facility Privacy Official.
We are required to agree to your request only if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose related to payment of health care operations (and not treatment purposes), and 2) your information pertains solely to health care services for which you have paid in full. For other requests, we are not required to agree. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we contact you at work instead of at home or in a private room, rather than in the waiting room. The facility will grant requests for confidential communication at alternative locations and/or alternative means if the request is submitted in writing and the written request include a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

A Paper Copy of this Notice:
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Changes To This Notice:

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with this facility. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses of Health Information
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you and documented in our facility.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Provide treatment and services
- Bill and collect payment from you, your insurance company, or a third party payer
- Conduct healthcare operations such as assess my care and outcomes and quality assessments

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of my rights and the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.* I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that this organization is not required to agree to my requested restrictions, but if the organization does agree then it is bound to abide by such restrictions.

____________________________________	________________________________
Patient Name	Date
X___________________________________	________________________________
Signature	Relationship to Patient