Therapies 4 Kids
Exceptional Care For Exceptional Children

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GENERAL THERAPY INTAKE FORM

Coming to a therapy clinic for the first time can be overwhelming and confusing. Here at Therapies 4 Kids, we are committed to make this experience as easy and comforting as possible. Please understand the importance of filling out this questionnaire. The information requested below is necessary for us to determine how much time to allow for the evaluation requested.

It is essential that we receive a completed form prior to the time of evaluation in order to best prepare testing and equipment required.

We have shortened our form to make this task as easy as possible for you and appreciate your compliance. After reviewing this initial intake form, we may ask that you provide additional information necessary to develop the best Plan of Care for you or your family member.

Please, bring with you prescription for evaluation(s), ID and insurance cards if any. Take your time to complete past medical history, education setting and background information, so we can best meet your family member's needs. Bring necessary equipment to meet your child's immediate needs and dress him/her in comfortable clothing and closed toe shoes.

What is your availability for the evaluation requested and future therapy appointments?

_____

We will do our best to accommodate your needs!

CLIENT INFORMATION

Name: _____ Preferred Name: _____

D.O.B: ___ / ___ / _____ Gender: ☐ M ☐ F

Primary Dx.: _____ Secondary: _____

Physician name / Company name: _____ **Phone #:** _____

Current status: *(Please include who the client lives with and including siblings, grade level of client special programs)*

_____

_____

Chief complaint / Why are you requestiong evaluation? _____

What services do you seek from us?: ☐ **PT** ☐ **OT** ☐ **Speech** ☐ **ABA** ☐ **Chiropractic** ☐ **Massage**
☐ **Acupuncture** ☐ **Other:** _____

Why you seek them? _____

What are your expectations for treatment? _____

_____

_____

Is the client being seen in any pain? ☐ Yes ☐ No If yes, please explain: _____

Interests: *(Please comment on likes, so we can best motivate him/her and engage therapeutic participation)*

_____

PARENT / CARE GIVER INFORMATION

Name(s): _____

_____

Contact information / Phone numbers: _____

Primary language: _____ Other: _____

Address: _____

_____

City: _____ State: ____ Zip code: _____ Country: _____

Emergency contact: _____

PAYMENT / INSURANCE INFORMATION

Method of payment: ☐ Self Pay ☐ Insurance Plan

Primary Insured name: _____ D.O.B: ___ / ___ / _____

Name of Insurance: _____ Member ID: _____

PAST MEDICAL HISTORY

Please describe any pertinent medical conditions, current medications, allergies, diet restrictions, adaptative devices or precautions to be considered: _____

_____

_____

_____

_____

Previous or current therapies / special services received; include dates, frequency and duration:

(Please bring any copies of previous evaluations and / or current goals) _____

_____

_____

BACKGROUND INFORMATION

Pregnancy term: _____ Complications: _____

Delivered: ☐ Vaginally ☐ C-Section Weight: _____ Apgar Score: _____

DEVELOPMENTAL HISTORY

Please state dates (weeks / months) obtained:

Sat alone: _____ Rolled over: _____ Crawled: _____ Cruising: _____ Walked: _____

First words: _____ Talk and functionally communicate: ☐ Yes ☐ No Toilet trained: ☐ Yes ☐ No

Eat finger foods independently: ☐ Yes ☐ No Feed self with ustensil: ☐ Yes ☐ No

Hand dominance: ☐ Right ☐ Left Obtained efficient grasping / hand function: ☐ Yes ☐ No

Please comment and report milestones and delays / complications, if any: _____

_____

_____

Fine Motor Skills: _____

Gross Motor Skills: _____

Social Function: _____

Sensory Concerns: _____

Activity Level: ☐ High ☐ Average ☐ Low

Comments: _____

Attention Span: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Comments: _____

SELF CARE AND SELF HELP SKILLS

Please comment how much client needs help and what they can perform independently.

Dressing: _____

Bathing / Hygiene: _____

Grooming: _____

Toileting: _____

Eating: _____

Mobility: _____

Postural Limitations: _____

School function: _____

Thank You!

We are looking forward to meeting you!

Therapies 4 Kids Staff