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Occupational Therapy Client Intake Form

Please return intake forms via email or fax as listed above

Today's Date: ______________________________

Child's Name: __________________________________ Parent(s) Name: ___________________________
Date of Birth: ____________________ Phone: _________________________________
Age: _______________________ Address: _______________________________
____

Parent Email Address:________________________________

Primary Physician: ____________________ Physician Group Name: _____________________
Diagnosis (if any): ____________________ Medications (if any): _______________________

Child lives with (check all that apply): □Mother □ Father □ Brother(s) □Sister(s) □Grandparent(s) □Guardian
Marital Status of Parent(s): □Single □Married □Divorced □Separated □Widowed
Parent Name(s):____
Mother's Place of Employment: __________________ Mother's mobile: ___________________________
Father's Place of Employment: ___________________ Father's mobile: ____________________________

Heath Insurance: □ Yes □No
Health Insurance Company: ____________________________________

Who we may thank for referring your child for occupational or speech therapy services?
____

Has child ever received occupational therapy? □Yes □No If yes, please state where: _____________________
Has child ever received speech therapy? □Yes □No If yes, please state where: _____________________

Developmental and Medical History:

1. Did water break more than 24 hours prior to delivery? □Yes □ No
2. Develop toxemia/high blood pressure? □Yes □No
3. Complications during labor or delivery? □Yes □No
4. Mother's age at delivery: __________

Birth History:

1. Was child full term? □ Yes □No Please list at how many weeks child was born: ________________
2. What was the child's weight? ______________
3. Was child born cesarean? □Yes □No
4. Was child born in breech position? □Yes □No
5. Did child require hospitalization? □Yes □ No If yes, please describe: __________________________

<u>Child's Health:</u>

1. Any known allergies? □ Yes □No If yes, please describe: ____________________________________
2. Has child had an eye exam by a doctor in last year?________________ if yes, by Dr. __________________
3. Does child wear glasses? (if yes, please state purpose)_________________________________
4. Any diet restrictions? □Yes □No If yes, please explain: _____________________________________
5. Has child had chronic ear infections in the past? □Yes □No
6. Did child require PE (ear) tubes? □Yes □No

7. Has child had any broken bones?_______________________________________
8. Please list any medical or surgical procedures to date:
   ____
9. Has child ever sustained a serious fall, or ever lost consciousness? If yes, please explain:____
   ____

Developmental Milestones: **Age Able to Perform Without Help:**
insert age or if unknown use: "N" for normal, "L" for late, "E" for early

Developmental Milestones	Age Able to Perform Without Help
Started babbling	
First word spoken	
Started eating with fingers (finger foods)	
Fed self with spoon	
Drank from a sippy cup	
Rolled over	
Sat without help	
Crawled	
Walked	
Potty trained	
Rode a bike without training wheels	

Self Help Skills:
1. Does child put on underwear, shirt and pants without help? □ Yes □ No
2. Does child tie shoes without help? □ Yes □ No
3. Does child consistently align zipper without help? □ Yes □ No
4. Does child consistently button without help? □ Yes □ No
5. Does child eat without help? □ Yes □ No
6. Given supervision, does child bathe/shower without help? □ Yes □ No
7. Does child put on socks without help? □ Yes □ No

Education, school and social history:
1. Where does your child currently attend school? ________________________________
2. What grade/ class ? __________________
3. Does your child receive any special support during his/her day (e.g. resource, speech therapy, counseling, etc):
   □ Yes □ No If yes, please list: ____
4. Has your child received any formal educational testing? □ Yes □ No If so, what and when?
   ____
5. Where will your child attend school next year (if known):
   ____
6. What extracurricular activities does your child participate?
   ____
7. In your opinion, what are your child's strengths?
   ____
   ____
   ____
8. What are your concerns about your child?
   ____
   ____
   ____
   ____

9. What have you been told by other professionals (doctors/teachers/etc) about your child's abilities and needs?

____

____

____

10. What do you hope your child will achieve by receiving services at Learning Charms?

____

____

____

Learning Charms Waiver

I understand that Learning Charms assumes no responsibility for injuries or illnesses which my child may sustain as a result of participation in any day camps, classes, individual tutoring, therapy, the use of any equipment, exercise, or other activities. I acknowledge that I assume the risk for any and all injury and illness which may result from participation in these. In consideration of the privilege of participating at Learning Charms, I hereby voluntarily release and discharge the Learning Charms and its agents, servants and employees, and contractors from any and all claims for injury, illness, death, loss or damage which may be suffered as a result of participation in these activities. A parent/responsible party must discuss with the Learning Charms director any special conditions or circumstances involving their child prior to registration. I agree to have a physician examine my child within a reasonable time prior to the start of the program/activity to determine my child is free of communicable disease and has not been exposed to such. I hereby give permission to the medical personnel selected by Learning Charms staff to order x-rays, routine tests, treatment, to release any records necessary for insurance purposes and to provide or arrange necessary related transportation for me/my child in the event of medical emergency. I understand that no accident/medical insurance is provided with this activity.

I have read, and agree with the waiver

____

Parent Signature

____

Parent Printed Name

If child enrolls in Occupational therapy is 4 years or older, we often offer one piece of gum while supervised and when participating in fine motor and/or handwriting skills. Gum often will keep a child's mouth and mind busy while performing "difficult" work. Gum is also seen as a reward for most kids. We typically have gum choices such as "Juicy Fruit" or "Extra". Since gum can be considered as candy, we would like your permission to or to not offer.

___________________________ (signature)

My child can have a piece of gum during therapy

___________________________ (signature)

I do not want my child to have gum during therapy

Consent For Treatment, Release of Information, & Permission to use images

Client Name:___________________________________ Today's Date:______________

Request of Information Release: I authorize Learning Charms to **release and/or obtain** information about my child to/from the following (i.e. physician, specialist, school, etc):

____

________________________________ ___________________________

________________________________ ___________________________

Information to be released: (Any service provided by Learning Charms)
Evaluation _______ Progress Reports _______
Treatment Plan _______ Tests _______
Discharge Summary _______ Visit Notes _______
Specific Information NOT to be released (if any): _______________________________

____

____
Parent or guardian's signature

Permission to Photograph and Videotape (Optional): I give Learning Charms my permission to photograph and/or videotape my child to be used for therapeutic, educational and advertising purposes. Names and other identifying personal or service information would not be used under any circumstance.

____
Client/Guardian Signature Date

Policies, Procedures, and Consent for Treatment: I have received and read the Policies and Procedures and Notice of Privacy Practices from Go Your Own Way, Inc., DBA: Learning Charms and agree to the terms therein, including but not limited to Consent for Treatment and Financial Agreement. This signed consent shall remain in effect until client or guardian fills out a new consent.

____
Parent or Guardian's Signature

____
Parent of Guardian's Printed Name