Child Intake Form/Case History

Today's Date ____________________
Client Name: ______________________________ Nickname: _____________
Date of Birth: _______________ Age: __________ ☐ Male ☐ Female
Diagnosis (if known): ____
Parent(s) / Guardians: ____
Address: ____
City, State, Zip: ____
Contact Name #1: ____
Phone #1: _________________________ ☐ Cell ☐ Home ☐ Work ☐ Other
Contact Name #2: ____
Phone #2: _________________________ ☐ Cell ☐ Home ☐ Work ☐ Other
Email #1: _________________________ Email #2: ________________________
Emergency Contact Name (Please list someone in addition to the contacts listed above):
_____________________________Relationship: __________________________
Emergency Contact (Information): ____________________________________
Client's Physician: ____
Physician Phone Number: ____
Physician Address: ____
Other Physicians / Specialists Involved in Care:
Referring Physician: ________________ Phone Number ___________________
Physician Address: ____
Secondary Physician: ________________ Phone Number ___________________
Physician Address: ____

Insurance Information

Primary Insurance Carrier
Carrier Name: ____
Policy Holder Name: ____
Insurance ID#: ____
Group Number: ____
Date Insurance Began: ____

Employer: ____

Please circle the following organization of your insurance policy:

HMO PPO EPO Other

Secondary Insurance Carrier (If applicable)
Carrier Name: ____
Policy Holder Name: ____
Insurance ID#: ____
Group Number: ____
Date Insurance Began: ____
Employer: ____

Acknowledgement of Financial Responsibility

I, _______________________________, acknowledge that I am responsible and liable for all charges accessed for professional services rendered. I acknowledge that I am responsible for all charges regardless of my existing medical coverage. In the event my insurance company forwards payment directly to me, I will deliver such payment to Thrive Pediatric Therapy. I understand that I am responsible for meeting my insurance deductible and coinsurance and any noncovered services. Should my account balance become past due, the balance shall become immediately due and payable. I further authorize the release to my insurance company of any medical information necessary to process a claim, and hereby assign payment of all medical benefits to Thrive Pediatric Therapy.

Signature: ________________________________ Date: ________________

How did you hear about [Private Practice / Private Practitioner Name]?
____

Family Background
Parent 1 Name: _________________________ Age: ______
Occupation: ___________________________ Education Level: _________
Parent 2 Name: _________________________ Age: ______
Occupation: ___________________________ Education Level: _________
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed.

What adults does the child live with? Check all that apply:

☐Birth Parent(s) ☐Adoptive Parent(s) ☐Foster Parent(s)
☐Grandparent(s) ☐Both Parents ☐Parent 1 Only
☐Parent 2 Only ☐Other: ____
Does the child have siblings?
Child 1 Name: ______ Age: __ Sex: __ Health Issues: _________________
Child 2 Name: ______ Age: __ Sex: __ Health Issues: _________________
Child 3 Name: ______ Age: __ Sex: __ Health Issues: _________________
Child 4 Name: ______ Age: __ Sex: __ Health Issues: _________________
Language(s) spoken in the home: ___________________________________
Who speaks the other language(s)? _________________________________
If anyone else in the family has a speech or language diagnosis, please describe it: ____
____
____

Evaluation:

Briefly describe why you're seeking an evaluation by our therapist(s):
____
____
____
Has the child had a previous ST/OT/PT evaluation/treatment?
☐Yes ☐No By whom: ________________________When: ______________
Describe the results: ____
____
____
At what age did you first notice the problem? _________________________
How do the child's communication difficulties impact the family? ___________
____
____
Medical History
Describe any pertinent information about the child's medical history (surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom:
____

Mother's Health During Pregnancy:

1. Were there any infections or illnesses? ☐Yes ☐No
Describe: ____
2. Was there any stress during the pregnancy? ☐Yes ☐No
Describe: ____

3. Were there any complications during labor or delivery? ☐Yes ☐No
Describe: ____
4. What was the mother's age at the time of delivery? ____ years
Child's Health:
1. How many weeks gestation was the child born? __ weeks (40 weeks is typical)
2. The child was _____ lbs. ____oz and _______ inches at birth
3. How was the child delivered? ☐ Vaginally ☐ Cesarean Section

Check and describe all that apply:

☐ Adenoidectomy Describe: ______________________________
☐ Asthma Describe: ____________________________________
☐ Behavior Issues Describe: _____________________________
☐ Brain injury Describe: _____________________________
☐ Breathing problems Describe: _____________________________
☐ Cardiac issues Describe: _____________________________
☐ Diabetes Describe: _____________________________
☐ Ear infections Describe: _____________________________
☐ Ear tubes Describe: _____________________________
☐ Frequent colds Describe: _____________________________
☐ High fever Describe: _____________________________
☐ Joint injury Describe: ______________________________
☐ Seizures Describe: _____________________________________
☐ Sensory issues Describe: _____________________________
☐ Sleep issues Describe: _____________________________
☐ Tongue tie Describe: _____________________________
☐ Tonsillectomy Describe: ______________________________
☐ Vision issues Describe: _____________________________
Is the child up to date with immunizations? ☐ Yes ☐ No
Please describe: ____
____
____
Has the child ever had any accident? ☐ Yes ☐ No
Please describe: ____
____

Does the child have a chronic illness? If so, please describe: ____________
____
____
Is the child currently on any medications? If so, please list medication name and reason for medication:
Medication 1: ____
Medication 2: ____
Medication 3: ____
Does the child have any known allergies? ☐ Yes ☐ No
Describe: ____
____
____
Does the child currently use any equipment? (Communication device, walker, etc.) Describe: ____
____
____
Does the child have any known hearing loss? ☐Yes ☐No
Describe: ____
____
____
Is the child currently receiving any of the following services (outpatient/school system)? If yes, please list the person's name and last date of service.
☐Developmental Pediatrician ____
☐Neurologist ____
☐PT ____
☐OT ____
☐SLP ____
☐Behavioral Therapist ____
☐Educational Consultant ____
☐Psychologist / Psychiatrist ____
☐Vision Therapist ____
☐Other: ____

Developmental History:

At what age did the child do the following:
Sit alone: ____________ Crawl: ___________________
Stood Up: ____________ Walk: _______________
Made Sounds: ___________ First Word: __________

Combined Words: ___________ Sentences: ________________
Fed Self: _______________ Understood by Others________
Toilet Trained: _____________ Dressed Self: _______________
Does the child do any of the following:
☐Choke on liquids ☐Choke on foods
☐Avoid foods ☐Maintain a special diet
☐Use a pacifier/suck thumb ☐Mouth objects
Please describe any of the above: ______________________________________
____
If under 4 years of age, how many words does the child say:
☐0-20 ☐21-50 ☐51-100 ☐101-150 ☐151-300 ☐301-500 ☐501+
Does the child produce sentences of the following length?
☐2 words ☐3 words ☐4 words ☐5+ words
What percentage of the child's speech do you understand? ________%
How well do people outside of the family understand their speech? ______%
If the child is not using words, how do they communicate? _______________
____
Does the child have any difficulty with the following?
☐Attention ☐Frustration Tolerance
☐Aggression ☐Anger
☐Answering simple questions ☐ Answering – "wh" questions
☐ Understanding people ☐ Following directions
☐ Excessive drooling ☐Chewing or eating
☐Producing speech sounds ☐Stuttering
☐Reading ☐School work
☐Remembering ☐Maintaining eye contact
☐Transitions ☐Word Retrieval
☐Other difficulties: ____
Please describe any of the above: ______________________________________
____
____

Educational History:

Is the child currently enrolled in daycare/ school: ☐ Yes ☐ No
What is the name of the program/days attended/grade level?
____
If they receive any accommodations, please describe: ____________________
____
____

Social History:

Describe how the child interacts with parents, siblings, or other family members/any difficulties had at home:

____

____

Describe any significant events or changes within the home: ________________

____

What are the child's strengths? ______________________________________

____

____

What are the child's weaknesses? ___________________________________

____

____

What are the child's favorite activities? _______________________________

____

____

Does the child become easily frustrated with certain activities? If so, please explain:

____

____

Describe how the child interacts with other children: _______________________

____

____

Is there anything else that is important for us to know about the child?

____

____

Consent for Services:

☐ **I authorize** Thrive Pediatric Therapy to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree, and understand that I have the right to refuse treatment or terminate services at any time by Thrive Pediatric Therapy in writing. In addition, Thrive Pediatric Therapy may terminate services by notifying me in writing.

☐ **I do not** give my consent or am withdrawing my consent regarding Thrive Pediatric Therapy rendering evaluation and therapy services to the client named below.

Date: ____________________

Printed Name of Client: ____

Client Date of Birth: ____

Signature of Client or Legal Representative:

____

General Acknowledgement of Forms:

☐ I hereby acknowledge and agree that I had read all the forms and documents provided to me in connection with evaluation and treatment provided by Thrive Pediatric Therapy and/or their employees.

☐ I understand the meaning and intent of the provided forms and agree to all content included.

☐ I have been given an opportunity to ask questions about the provided forms and all questions I've asked have been answered to my satisfaction by Thrive Pediatric Therapy.

____

Print Name of Client Date

____

Signature of Participant or Legal Representative Relationship to Client

Authorization to Exchange, Obtain or Release Information:

Client Name: ___________________________
Date of Birth: ___________________________
Home Address:
____

I __________________________ (client or family member) hereby grant Thrive Pediatric Therapy permission to communicate with the following person or agency:

Name:
Contact Information:

Information to Be Released:

☐ Medical History
☐ Therapy Evaluation
☐ SLP ☐ OT ☐ PT ☐ Other: _______________
☐ Treatment Notes
☐ SLP ☐ OT ☐ PT ☐ Other: _______________
☐ School Records (Evaluations, IEP, academic reports, etc.)

For the Purpose Of: (check all that apply)

☐ Coordinating care with other professionals
☐ Providing continuity of services
☐ Updating therapeutic progress
☐ Other
____

☐ I grant permission to exchange information via written and mailed report, phone call, **meeting, email, or fax.**
☐ I understand that unless revoked, this authorization will remain valid until written **revocation of this authorization is presented.**

____
Print Name of Client Date

____
Signature of Client or Legal Representative Relationship to Client

Communication Preference:

Client Name: __________________ Date of Birth: __________________

To ensure your privacy, it is important for us to understand your preferred method of receiving and communicating medical and administrative information pertaining to your therapy. As such, please indicate your communication preferences below.

For medical and administrative information pertaining to me such as clinical documentation, appointment reminders, therapy updates etc. I hereby grant permission to Thrive Pediatric Therapy do the following:

Written Documentation and Verbal Information

☐ I grant permission to provide me with written communication via HIPAA compliant encrypted email service via my email provided.

☐ I grant permission to provide me with written communication via unencrypted email service. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

☐ I grant permission to provide me with written communication (such as appointment reminders or cancellations) via text message. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

☐ I grant permission to provide me with written communication via USPS in an unmarked envelope.

☐ I elect to receive clinical information in person or via telephone through the number provided.

☐ I grant permission to leave relevant medical information on my answering machine or voicemail. I also give permission to release medical information pertaining to the client to the individuals listed below:

Sharing of Information:

Individual’s Name Relationship to Client Email Address and/or Phone Number

1.

2.

I understand that it is my responsibility to inform the practice of changes to my preferred contact information or my communication preferences, as well as to revoke this authorization at any time.

____

Print Name of Client Date

____

Signature of Client or Legal Representative Relationship to Client

Acknowledgement & Assumption of Risk:

☐ I, ____________________ (client or parent/guardian name) understand that I am being asked to carefully read each of the provisions in this form. I acknowledge and agree to have _______________________ (client name) receive therapy services from Thrive Pediatric Therapy and/or any employee or independent contractor employed by self.

☐ I acknowledge that there are some inherent risks associated with the use of therapy equipment that cannot be eliminated regardless of the care taken to avoid injuries.

Some of unlikely but potential injuries include:

____

____

I understand the risks and I hereby assert that my participation is voluntary and that I knowingly assume such risks without holding Thrive Pediatric Therapy and/or any employee or independent contractor employed by self-accountable for any losses, injuries or other damages occurring to the client and/or myself. I further understand that I am fully responsible for my own safety.

____

Print Name of Client Date

____

Signature of Client or Legal Representative Relationship to Client

Acknowledgement That You Have Received Our HIPAA Privacy Notice:

Thrive Pediatric Therapy is required by law to keep your health information and records safe.
This information may include:

• Notes from your doctor, teacher, or other healthcare provider
• Medical history
• Test results
• Treatment notes
• Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared.

☐ I acknowledge that I have received a copy of Thrive Pediatric Therapy Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

☐ I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

☐ I understand Thrive Pediatric Therapy cannot disclose my health information other than as specified in the notice.

☐ I understand that Thrive Pediatric Therapy reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

____
Print Name of Client Date

____
Signature of Client or Legal Representative Relationship to Client

Please Note: It is your right to refuse to sign this Acknowledgement.
HIPAA Privacy Notice Acknowledgement

Informed Consent for Text (SMS) Messaging

With your consent, **Thrive Pediatric Therapy** would like to send text (SMS) messages to the mobile number you have provided in our records.

By providing your informed consent where indicated, you acknowledge that you have understood the information below and agree to participate in our text (SMS) messaging service.

Purpose and Description: **Thrive Pediatric Therapy**'s text (SMS) messaging service is designed to provide you with helpful information, reminders, and notifications via text messages sent to your mobile phone. We may use text (SMS) messages to communicate with you for a variety of purposes, including but not limited to:

- **Announcements and reminders of upcoming events**
- **Courtesy reminders about upcoming appointments**
- **Potential weather delays or closures**

Voluntary Participation: Participation in our text (SMS) messaging service is entirely voluntary. You have the right to refuse or withdraw your consent at any time.

Benefits and Risks: Benefits: The text (SMS) messaging service aims to keep you informed about **Thrive Pediatric Therapy** by providing an additional method of convenient and timely communication.

Risks: While every effort will be made to protect the security and confidentiality of information transmitted through text (SMS) messages, there are inherent risks associated with all electronic communication. These risks include unauthorized access, loss of privacy, and potential breach of sensitive information. It is important to be aware that text (SMS) messages may not be entirely secure and could be intercepted or accessed by unintended recipients.

Potential Costs: Participation in the text (SMS) messaging service may involve standard text messaging charges applied by your mobile service provider. Please consult your mobile service provider regarding any applicable fees or charges.

CONSENT FORM FOR TEXT MESSAGING REMINDERS

I give permission consent to receive text messages from Thrive Pediatric Therapy or others acting on Thrive Pediatric Therapy's behalf. As part of this consent, you represent and warrant the following:

(1) **Thrive Pediatric Therapy or others acting on their behalf** may send text messages in various formats and with various contents, including but not limited to, text messages about appointment reminders.

(2) **You are the owner or authorized user of the mobile phone number identified below**. You will notify us immediately if you are no longer the owner or authorized user of the mobile phone number identified below.

(3) You are solely responsible for any message and data charges associated with such text messages. If You do not wish to receive text messages from Thrive Pediatric Therapy or others acting on their behalf, you should not sign this form.

Printed name: ____

Signature: _______________________________________Date: ____________

Patient's name: ____

Mobile phone number (Primary): _____________________________________