675 3rd Avenue, Jasper, IN 47546
(812) 351-1490
(812) 301-1329 fax
www.pts-jasper.com

Child Intake Form / History

Today's Date _____

Client Name: _____ Nickname: _____
Date of Birth: _____ Age: _____ ☐ Male ☐ Female
Diagnosis (if known): _____
Parent(s) / Guardians: _____
Address: _____
City, State, Zip: _____
Phone #1:_____ ☐ Cell ☐ Home ☐ Work ☐ Other
Phone #2:_____ ☐ Cell ☐ Home ☐ Work ☐ Other
Email #1:_____ Email #2: _____
Emergency Contact Name: _____
Emergency Contact Relationship to Child: _____
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: _____

How did you hear about us?
_____

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 or are there other siblings in the home?

Child 1 Name: _____ Age: __ Sex: __ Speech/Medical Issues:_____
Child 2 Name: _____ Age: __ Sex: __ Speech/Medical Issues:_____
Child 3 Name: _____ Age: __ Sex: __ Speech/Medical Issues:_____
Child 4 Name: _____ Age: __ Sex: __ Speech/Medical Issues:_____
Child 5 Name: _____ Age: __ Sex: __ Speech/Medical Issues:_____

Language(s) spoken in the home: _____
Who speaks the other language(s)? _____
Describe the child's use/understanding of the language(s): _____
_____

Is there anything additional you would like to share about the family / home environment? _____
_____
_____

Evaluation

Briefly describe why you're seeking an evaluation at this time:
_____
_____
_____
_____

What are you expecting out of this evaluation / meeting? _____
_____
_____

Describe in your own words the nature of your concerns about the child's development and/or the primary referral reasons: _____
_____
_____
_____

At what age did you first notice the problem? _____

How do the child's communication difficulties impact the family? _____
_____
_____

Is the child aware of or frustrated by their difficulties? _____
_____
_____

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
4. Please describe any complications or concerns during labor or delivery:
_____
_____
_____

Check and describe all that apply:

- ☐ ADD/ADHD Describe: _____
- ☐ Adenoidectomy Describe: _____
- ☐ Allergies/Asthma Describe: _____
- ☐ Anxiety/Depression Describe: _____
- ☐ Bedwetting Describe: _____
- ☐ Behavior Issues Describe: _____
- ☐ Brain injury Describe: _____
- ☐ Breathing problems Describe: _____
- ☐ Cardiac issues Describe: _____
- ☐ Chicken pox Describe: _____
- ☐ Daytime Fatigue Describe: _____
- ☐ Diabetes Describe: _____
- ☐ Ear infections Describe: _____
- ☐ Ear tubes Describe: _____
- ☐ Encephalitis Describe: _____
- ☐ Frequent colds Describe: _____
- ☐ Headaches Describe: _____
- ☐ High fever Describe: _____
- ☐ Measles Describe: _____
- ☐ Meningitis Describe: _____
- ☐ Mumps Describe: _____
- ☐ SDB/OSA Describe: _____
- ☐ Seizures Describe: _____
- ☐ Sensory issues Describe: _____
- ☐ Sleep issues Describe: _____
- ☐ Snoring Describe: _____
- ☐ Swallowing Difficulties Describe: _____
- ☐ Tongue tie Describe: _____
- ☐ Tonsillitis Describe: _____
- ☐ Tonsillectomy Describe: _____
- ☐ Traumatic brain injury Describe: _____
- ☐ Vision issues Describe: _____

Is the child up to date with immunizations: ☐ Yes ☐ No

Please describe: _____

_____

_____

Has the child ever had surgery? ☐ Yes ☐ No

Please describe: _____

_____
_____

Has the child ever been hospitalized: ❒ Yes ❒ No
Please describe: _____
_____
_____

Has the child ever been in a serious 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: _____
Medication 4: _____

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 a history of ear infections, tubes, etc. or use hearing aides?
❒Yes ❒No
Describe: _____
_____
_____

Does the child have any known hearing loss? ❒Yes ❒No
Describe: _____
_____
_____

If you have any concerns about the child's hearing, please describe: _____
_____
_____

Describe the child's current health status: _____
_____
_____

Is the child currently receiving any of the following services? 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
❒Crawling	❒Self Dressing
❒Walking	❒Cutting
❒Coordination of movements	❒Writing
❒Managing emotions	❒Tolerating new environments

❒Other difficulties: _____
Please describe any of the above: _____
_____
_____

Has the child experienced any difficulty with feeding or swallowing? If so, please describe: _____
_____
_____

Educational History

Is the child currently enrolled in daycare/ school: ❒ Yes ❒ No

What is the name of the program? _____

What day(s) do they attend? _____

What is their grade level: _____

Type of classroom: _____

If they receive any accommodations, please describe: _____
_____
_____

Please describe any educational difficulties or learning challenges that this child has faced: _____
_____
_____

Social History

Describe how the child interacts with parents, siblings, or other family members: _____
_____
_____

Please describe the communication difficulties the child faces in the home environment: _____
_____
_____
_____

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 participate in any community activities (ex. play groups, sports, etc.) and how is their communication / behavior? _____
_____
_____

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

Describe how the child interacts with other children: _____
_____
_____

What are your goals for the child over the next 6 months? _____
_____
_____
_____

What are your goals for the child over the next 5 years? _____
_____
_____
_____

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

Person filling out the form: _____
Relationship to the child: _____

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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 Pediatric Therapy Specialties and/or any employee or independent contractor employed by Tiny Tots Speech Therapy and/or PT for Kids, Inc.

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

I understand the risks and I hereby assert that my participation is voluntary and that I knowingly assume such risks without holding Pediatric Therapy Specialties and/or any employee or independent contractor employed by Tiny Tots Speech Therapy and/or PT for Kids, Inc 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

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Attendance / Cancellation Policy

Attendance and participation in therapy along with complete compliance with any associated home programs, are essential for therapeutic success.

While Pediatric Therapy Specialties understands that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or "no shows". Please adhere to our following policy regarding providing our office with advance notification for any cancellations resulting from a conflicting appointment, vacation, obligations for work or family, or any other event.

All cancellations must be submitted **12 hours** prior to your scheduled appointment.

☐ A fee of **$25** may be assessed if the following occurs. This fee will be billed directly to the client and not their health insurance company, as medical insurance does not provide coverage for missed sessions.

1. If cancellations are made less than the required 12 hours.
2. If the client fails to show up for a scheduled appointment.

☐ If you reschedule / are late for **2 scheduled appointments within 30 days**, the office will reserve the right to discharge the client. Additionally, if you arrive late for a scheduled appointment, the session will still end at the scheduled time or may be cancelled.

☐ If you fail to appear for an appointment (no show) without providing the appropriate advance notification for 2 or more appointments within 30 days, the office will reserve the right to cancel all pending appointments and to no longer offer services to you as a client.

☐ I, _____, understand the attendance / cancellation policy and the risks of not adhering to it.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

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Payment Policy & Fee Schedule

Thank you for choosing our private practice to serve you. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and Pediatric Therapy Specialties for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client of Pediatric Therapy Specialties, Tiny Tots Speech Therapy and/or PT for Kids, Inc, you are required to carefully review and sign our payment policy.

Fee Schedule

Fee schedule available upon request. Pricing will be discussed with parent at the time of the evaluation.

Please read the following information carefully:

All therapy fees (including session fees and/or co-pays, if applicable) are due within **15 days of receipt of the invoice.**

We accept the following payment methods at this time cash, checks, PayPal, Apple Square, credit cards, HSA.

Checks should be made payable to:
Speech: Tiny Tots Speech Therapy
Physical/Occupational Therapy: PT for Kids, Inc

We will provide you with an invoice outlining the services rendered and the amount charged.

Name of Client: _____ Date of Birth: _____
Please read and check all boxes to acknowledge understanding and the sign below:

☐ I understand that I am responsible for all costs / fees that any third-party payer (ex. insurance company, private school, etc.) does not cover. In the event that a third-party payer source determines that rendered therapy services are “not covered” or otherwise denied, I will be responsible for all outstanding charges. I

understand that I will be billed accordingly and will be responsible for immediate payment. I also understand that Pediatric Therapy Specialties, Tiny Tots Speech Therapy or PT for Kids, Inc will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial.

☐ I understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.

☐ I understand that all returned checks will be subject to a $25 returned check fee. Charges incurred and not paid after 30 days may be turned over to a collection agency at the client's expense. Overdue accounts may also be reported to a Credit Bureau.

☐ I understand that I am responsible for all legal and collection fees, which Pediatric Therapy Specialties, Tiny Tots Speech Therapy or PT for Kids, Inc may incur if payment is not made in accordance with the terms and conditions herein.

☐ I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within 15 days after the overpayment is discovered on the client's bill or at the time the refund is requested. Refunds for payments made with a credit card will be credited back to the credit card used, all other refunds will be issued by a check. Client's who used a third-party source will not be issued a refund until full payment is received from the appropriate source.

☐ I, understand that all cancellations require 12 hours notice and that there will be a $25 charge for any cancellations made less than 12 hours. This charge is my sole responsibility and will not be covered by a third-party source.

☐ I, _____, (client / guardian name) understand the payment policy and the risks of not adhering to it.

_____ _____
Print Name of Client Date of Birth

_____ _____ _____
Signature of Client, Guardian or Responsible Party Relationship to Client

_____ _____
Private Practitioner / Witness Date

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Authorization to Exchange, Obtain or Release Information

Client Name: _____ Date of Birth: _____
Home Address: _____
_____

I _____ (client or family member) hereby grant Pediatric Therapy Specialties 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

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Consent and Release of Photographs / Videos

☐ I, _____ (client or parent/guardian name) give consent to Pediatric Therapy Specialtiers or any party authorized by Tiny Tots Speech Therapy or PT for Kids, Inc to photograph and/or video record _____ (client name) in connection with his/her therapy sessions, for any purpose subject to the therapist's discretion including but not limited to educational publication, for teaching purposes, and demonstration of progression of his/her skills.

☐ I authorize Pediatric Therapy Specialties to use pictures of _____ (client name) for promotional purposes (ex. brochures, website, etc.)

☐ I acknowledge that I will receive no financial compensation for providing consent since my participation with Pediatric Therapy Specialties in providing my consent and release is voluntary.

☐ I hereby release Pediatric Therapy Specialties, their contractors, their employees and/or any third parties involved in the creation or publication of Tiny Tots Speech Therapy and/or PT for Kids, Inc. Publication from any and all liability that may arise in connection with the expressed and implied use of all photographs and videos outlined in this form.

☐ I reserve the right to revoke this agreement at any time. I understand that my right to revoke must be done in writing.

I am the client, parent or legal guardian of the person named below and have the legal authority to execute this consent and release.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

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Acknowledgement That You Have Received Our HIPAA Privacy Notice

Pediatric Therapy Specialties 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 maybe used and shared.

☐ I acknowledge that I have received a copy of Pediatric Therapy Specialties' HIPAA 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 Pediatric Therapy Specialties cannot disclose my health information other than as specified in the notice.

☐ I understand that Pediatric Therapy Specialties 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.

Office Use Only

I tried to obtain written Acknowledgement of our Privacy Notice by the patient/legal representative noted above. It could not be obtained for the following reason(s)

3. An emergency prevented us from obtaining acknowledgement.
4. The individual was unwilling to sign.
5. A communication barrier prevented us from obtaining acknowledgement.
6. Other: _____

_____ _____

Staff Member Signature Date

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment 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.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include 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 create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

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.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information. The right to amend your protected health information.

The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the polices and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact the following for more information:

The U.S. Department of Health & Human Services Office of Civil Rights

200 Independence Avenue, S.W.

Washington, D.C. 20201

(202) 619-0257

Toll Free: 1-877-696-6775