FUNDAMENTALS
THERAPY

In-Take Forms
-CONFIDENTIAL-

Please complete this intake questionnaire regarding your child. Feel free to add any additional information or attach additional reports that you think may helpful for us in getting to know your child. Fundamentals Therapy views all of the information that you provide us with as strictly confidential. This information is helpful for us in developing an initial understanding of your child's needs and provides critical information for us to discuss with your insurance company to get authorization for services.

Patient Information

Last Name _____ First Name _____ Middle Name _____ Gender _____

Date of Birth _____ Age _____ Social Security Number _____

Address _____ City _____ State _____ Zip Code _____

Child's Pediatrician _____ Pediatricians Phone Number _____ Pediatricians Office Name, City _____

How did you hear of our agency? _____

PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian Name: _____

Relationship to Child: _____ Contact Phone Number: _____

Parent/Guardian: _____

Relationship to Child: _____ Contact Phone Number: _____

Child Lives with (Please select one): ☐ Birth Parents ☐ Foster Parents ☐ Adoptive Parents
☐ One Parent ☐ Other

Insurance Information

Primary Insurance _____ Policy Holders Name _____ Policy Holders DOB _____ Policy# & Group# _____

Secondary Insurance | Policy Holders Name | Policy Holders DOB | Policy# & Group#

Why are we seeing you today?

Reason for Referral (check all that apply): ☐ Occupational Therapy ☐ Speech Therapy ☐ Behavioral Therapy

What goals do you have for you child?_____

What are your main concerns regarding your child's development?_____

MEDICAL INFORMATION

Birth History
Child was born: Full Term ☐ Premature ☐ How many weeks premature?_____
Delivery: Vaginal ☐ C-Section: ☐
Did you have any complications?

Was your child placed in the NICU, if so how long? _____

Please describe any other prenatal medical problems or complications at birth: _____

Medical History

Does your child/adolescent have any allergies ? Yes ☐ No ☐ If yes please list: Also indicate if EPI pen is needed:

Is your child/adolescent currently taking any medications? Yes ☐ No ☐
If yes please, what:_____

Does your child have any Current or ongoing Health Concerns:_____

Which hand does your child/adolescent show dominance? Left ☐ Right ☐ No preference ☐

Does your child/adolescent have any current health conditions, including infectious diseases?
Yes ☐ No ☐
* If yes, please explain below.

List any surgeries or hospital stays including approximate age:

Does your child/adolescent have any vision problems? Yes ☐ No ☐

* If yes, please explain below and if there are any treatments currently being used for correction.

Does your child/adolescent have any hearing problems or history ear infections? Yes ☐ No ☐

* If yes, please explain below and if there are any treatments currently being used for correction.

Date of last hearing screening: ☐

Does your child/adolescent have a history of seizures? Yes ☐ No ☐

* If yes, please describe the types of seizures and current treatment.

Does your child/adolescent have any assistive devices/DME (example AFO, bath chair, walker, w/c, splint etc.)?
Yes ☐ No ☐

* If yes, please describe:

Please check all that apply:

_____ Hearing Aids ____ Ear Tubes ___ G-Tube ____C-Line ___Reflux

____ History of Broken Bones ____ Neurological Condition

___ Psychological Disorder ___ Pain ___ Diabetes

Explanation of Any Medical Condition:

Has your child received any developmental evaluations? If "yes" please put where and who conducted the evaluation:

Developmental Milestones: (Mark Approximate Month):

___ Rolled Over ___ Babbled ___ Crawled ___ Said First Word ___ Sat Up Alone

___ Pulled up ___ Walked Alone ___ Drank from a Cup ___Used a Spoon

___ Finger Fed ___ Held a Cup/Bottle ___ Pointed to Named Object

___ Responded to Name ___ Dressed Self ___ First Spoken Sentence

____ Toilet Trained

Gained Bladder Control: day____ night____

Gained Bowel Control: Day_____ night____

Does your child have any current physical limitations: _____

_____

Speech and Language

Describe your child's current speech/language concerns: _____

_____

Describe your child's communication at the present time (Please check all that apply)

_____Grunts and points _____Copies what you say _____Stutters
_____Screams _____ Single words _____Too soft
_____Gestures _____Two-word phrases _____Too loud
_____Takes you to objects _____Longer sentences _____Hoarse
_____Copies what you do _____Unclear speech _____ Responds to name
_____Points to objects when asked _____ Follows simple directions
_____ Gets objects from another room when asked
_____ Points to body parts when asked _____Answers simple questions
_____ Point to picture in book when asked
_____Points to family members when asked
_____Understands prepositions (e.g. under, on, in, to)
_____ Engages in pretend or imaginary play
_____ Understands colors and size words (e.g. big, small)

Please circle the phrase that best describes how the client currently communicates:

Pointing/Gestures	Simple 3-4 word phrases
Babbling	Sentence with some errors
Manual Sign	Grammatically correct sentence
Single Word	Tells stories and explains what happened
Two-word combinations	

Indicate any family history of speech or language problems: _____

_____

Has the patient received any speech/ language evaluations prior to today? If "yes" please put where and explain what treatment was received: _____

_____

_____

Feeding History

Did you child have any difficulty feeding?(e.g. chocking with liquids, difficulty managing solids, trouble transitioning to textures, poor weight gain, reflux etc.) _____Yes _____No

If yes please describe: _____

_____

Early Feeding: (Circle all that apply) Bottle Breast Both
Until what age: _____

Please check any problems that your child might be having with feeding/swallowing:

____ Gagging ____Choking ____Food Stuffing ___Reflux/GERD

____Excessive Drooling ____Pocketing/Holding
____ Solid Foods ____ Puree Foods _____ Picky Eater

____ Cup Drinking ____ Straw Drinking _____ Self-Feeding

Please describe checked items: _____

_____

Any nutritional concerns? _____

Food preferences that you've noticed? (Likes/Dislikes, Tastes, Textures) _____

_____

What are they eating with- utensils or hands? _____

Does your child see a nutritionist, if Yes who? _____

What does your child like to eat? _____

_____

_____

Occupational Therapy

Describe Dressing and Hygiene Skills:
How do they go about their routine- how much help do they need?
Do they dress themselves independently? (zippers, buttons, tie)
Tie own shoes? (shoes and socks)

_____

_____

_____

_____

Behavior
Please indicate if your child/adolescent engages in any of the following behaviors (check all that apply):

_____ Picky Eater ___ Puts Objects in Mouth ___ Teeth Grinding ___ Sensitive to light

____ Sensitive to Sound ___ Sensitive to Textures ___ Cries often

____ Loves jumping ____ Weak Muscles ___ Clumsy

____ Dislikes Teeth Brushing ____ Dislikes Hair Brushing ____ Struggles with Transitions

____ Sensitive to Touch ____ Avoids Touch from Others ____ Always "on the go"

____ Poor Attention Span ____ Repetitive Behaviors ____ Poor Attention Span

____ Appears to be Anxious ____ Difficulty with Separation ____ Trouble Attending to Task

____ Trouble Sleeping ____ Prefers to Play Alone ____ Trouble Following Directions

____ Has Trouble Making Friends ____ Has Trouble Playing With Others

___ Willing to Try New Things ____ Trying New Things is Hard

____ Withdrawn ____ Easily Frustrated ____ Impulsive ___ Restless

____ Eloping (running away from adult) ___ Inappropriate behaviors

___ Self Injurious Behaviors (hurting self) ___ Aggressive Behaviors towards others

___ Tantrums ___ Screaming/Yelling ___ Property Destruction

Please explain any of the above behaviors: _____

_____

_____

_____

_____

Do you feel that your child gets frustrated do to lack of communication or motor issues he or she may have?

_____

_____

What problem behaviors does your child exhibit at home? _____

_____

What problem behaviors does your child exhibit at school? _____

_____

Previous Therapy/School History

Please provide us with information regarding the following types of current or previous therapy providers and copies of any recent evaluations that indicate dates of previous treatment and therapeutic interventions and responses.

Does your child/adolescent currently receive behavioral services with another provider?

Yes (Please provide information below.)

No

Name of **Behavioral Provider**: _____

Provider Address: _____

Provider Phone Number: _____ Email: _____

Does your child/adolescent currently receive speech therapy services?
Yes (Please provide information below.)
No

Name of **Speech Therapy Provider**: _____

Provider Address: _____

Provider Phone Number: _____ Email: _____

Does your child/adolescent currently receive occupational therapy services?
Yes (Please provide information below.)
No

Name of **Occupational Therapy Provider**: _____

Provider Address: _____

Provider Phone Number: _____ Email: _____

Does your child/adolescent currently receive physical therapy services?
Yes (Please provide information below.)
No

Name of **Physical Therapy Provider**: _____

Provider Address: _____

Provider Phone Number: _____ Email: _____

Does your child/adolescent currently receive psychiatric services?
Yes (Please provide information below.)
No

Name of **Psychiatric Provider**: _____

Provider Address: _____

Provider Phone Number: _____ Email: _____

Does your child/adolescent currently receive any other services?
Yes (Please provide information below.)
No

Name of **Other Provider**: _____

Provider Address: _____

Provider Phone Number: _____ Email: _____

Is your child receiving therapy in school? YES ☐ NO ☐

Is your child on an IEP? YES ☐ NO ☐

Name of school currently attending and grade: _____

Services received in school:

___ OT ___Speech ___ PT ___ Special Education ___ Behavior Intervention

Does your child's teacher have any concerns with your child's development (if yes please explain)?

_____

Has your child repeated a grade?_____ If yes, when: _____

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Photograph Release Authorization Form For Social Media

Please read each of the following and check the appropriate box next to each statement and sign and date each area on this consent form.

I/We hereby **give permission and consent** to all staff of Fundamentals Therapy to photograph my child and/or myself during the time my child is enrolled in services. I/We understand these photographs may be used on our website or our social media pages. I understand pictures will be posted on our Facebook and Instagram pages online and in other communications related to the mission of Fundamentals Therapy PLLC. We will reference your child's name and provide specific information regarding your child's treatment at our facility.

I/We hereby **give permission and consent** to all staff of Fundamentals Therapy to photograph my child and/or myself during the time my child is enrolled in services. I/We understand these photographs may be used on our website or our social media pages. I understand pictures will be posted on our Facebook and Instagram pages online and in other communications related to the mission of Fundamentals Therapy PLLC. We will reference your child's name and provide specific information regarding your child's treatment at our facility. I request that you post a image over my child's face on all pictures.

I/We hereby **do NOT give permission and consent** to all staff of Fundamentals Therapy to photograph my child and/or myself during the time my child is enrolled in Speech/OT.

Client's Name: Date of Birth:

Parent/Guardian #1: _____ Date: ____ / ____ / ____
(Signature)

Parent/Guardian #2: _____ Date: ____ / ____ / ____
(Signature)

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Client Email & Texting Informed Consent

Client Name: _____

The purpose of this consent is to review the option of receiving program information and any confidential protected health information (PHI) by email or text. Please review the following and ask any questions related to these two topics before consenting with your signature below.

1. Risk of using email/texting The transmission of program information and/or your PHI by email and/or texting has a number of risks that you should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.

b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.

c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.

d. Employers and on-line services have a right to inspect emails sent through their company systems and potentially text messages sent through their company issued phone.

e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.

f. Email and texts can be used as evidence in court.

g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the use of email and texts Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Clients/parent's/legal Guardians must acknowledge and consent to the following conditions:

a. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.

b. Email and texts should be brief/concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.

c. All email may be printed and filed into the client's medical record. Texts may be printed and filed as well. This makes any information within the text or email a part of the client chart and will be discoverable upon audit, record request, subpoena, and/or court order.

d. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts outside of Del Mar Center for Behavioral Health providers without the client's/parent's/legal guardian's written consent, except as authorized by law.

e. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.

f. Provider is not liable for breaches of confidentiality caused by the client or any third party.

g. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between the Provider and me, and consent to the conditions and instructions outlined above, as well as any other instructions that the Provider may impose to communicate with client by email or text (any specific instructions will be documented within the progress notes of your chart). Based on my understanding of the risks, I consent to the following (check all that apply):

☐ Email communications ☐ Text communications

☐ I do not wish to communicate via email or text

This consent will remain active until the time of discharge from program services or at the time the consent is revoked (whichever is earlier).

Client signature: Date:

Parent/Legal Guardian name:

Parent/Legal Guardian signature: Date: