Kids In Motion Therapy Clinic

4152 Meridian Street, Suite 105 PMB 159,

Bellingham, WA 98226

CHILD INTAKE FORM

Office Use Only:
Assigned to:_____ OT_____ PT_____ SLP____ Intake Date__/__/___

PATIENT INFORMATION

LAST NAME: FIRST: D.O.B: / / SEX: M / F

HOME ADDRESS: CITY: STATE: ZIP CODE: HOME PHONE:

PARENT INFORMATION

MOTHER'S LAST NAME: FIRST: FATHER'S LAST NAME: FIRST:

MARITAL STATUS: SINGLE ( ) MARRIED ( ) OTHER ( )

EMPLOYER NAME: WORK PHONE: CELL PHONE:

WORK ADDRESS: CITY: STATE: ZIP:

REFERRING PHYSICIAN INFORMATION

LAST NAME: FIRST: ADDRESS: TELEPHONE:

DO YOU HAVE A PRESCRIPTION: YES / NO TAX ID #

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

LAST NAME: FIRST: WORK/CELL PHONE: HOME PHONE:

ADDRESS: CITY: STATE: ZIP:

RELATIONSHIP: EMERGENCY CONTACT ( ) PARENT ( ) GUARDIAN ( )

REASON FOR TODAY'S VISIT

DIAGNOSIS:

Has your child ever received PT, OT OR SLP? Y / N If yes, when and where?

PHYSICAL:
Is your child having difficulty rolling, sitting or walking? YES or NO

Does your child have balance and difficulties? YES or NO

OCCUPATIONAL:
Do you have concerns with your child's: Eating skills? _____ Grooming/Hygiene? _____

Eye-Hand coordination? _____ Handwriting _____ Dressing skills?_____

Does your child play with toys appropriate for his/her age? _____

4152 Meridian Street, Suite 105 PMB 159,

Bellingham, WA 98226

Birth Information (Check all those that apply)

Complications/Health problems during pregnancy:
Diabetes____Measles____Toxemia____Premature labor____Strep____Respiratory_____

Other_____

Complications during Labor/Delivery:
Cesarean Section_____Emergency Y /N Please Describe_____

_____
Describe Child's Condition at/or immediately after Birth:
Premature____(If yes) Gestational age_____Apgars_____NICU_____Other_____
Ventilator____(If yes) How Long?_____Jaundice_____Heart Problems____Poor Suck_____
Small for Gestational Age_____Large for Gestational Age_____
Known Diagnosis (e.g. Down's Syndrome)_____
Other Medical Complications_____

Child's Medical History:
Measles_____Mumps_____Pneumonia_____Chicken Pox_____Bronchitis_____BPD_____
Reflux_____Allergies_____Head Injuries_____Tonsillitis_____Other_____
Ear Infections_____Frequency_____Last Ear Infection_____
Treatment Method_____

List Any Hospitalizations_____

1. Does your child have asthma, hay fever, eczema, or rashes?	YES	NO
2. Is your child allergic to bananas, avocados, chestnuts, nuts, or kiwi?	YES	NO
3. Allergic to potatoes, milk, peaches, tomatoes, papaya, or passion fruit?	YES	NO
4. Is your child allergic to any food?	YES	NO
If yes, please state: _____		
5. Is your child on any special diet?	YES	NO
If yes, please describe:_____		
6. Is your child allergic to lotions, essential oils, perfumes, etc?	YES	NO
If yes, please describe:_____		

List Any Surgeries Performed:
Ear tubes_____ Still in Place?_____ Central Line_____ Sinal Infusions_____ G-Tube____
Heart Repair_____ Trach_____ Shunt____ Tonsillectomy_____ Appendectomy_____

Other_____

Tests Performed:
MRI____ CT Scan____ Genetic Testing_____X-Rays____ Other_____

Please List Current Medications:_____
_____

Has your Child had any Seizures? Yes or No?
Please Describe and Indicate Frequency_____

4152 Meridian Street, Suite 105 PMB 159,

Bellingham, WA 98226

Child's Developmental History

Developmental Milestones:
Please List the approximate age the child accomplished the following:
Lift head while on tummy_____ Rolled Over_____ Sat without support_____
Crawled_____ Stood alone_____ Walked alone_____ Dress/Undress self_____
Button/Zip clothes_____ Started solid food_____ Held cup_____ Used fork_____
Drank from sippy cup_____ Open cup_____ Dry during day_____ Night_____
Gain bowel control_____ Hand Preference Left_____ Right_____
Does your child have any bladder or bowel difficulties? Yes / No
Please Describe_____

Speech

Please list the approximate age that child accomplished the following:
Babble (dada, baba, etc.)_____Said first words_____Combined words_____
Does your child respond when his/her name is called? Y / N Follow simple directions Y / N
Approximately how many words does your child have?_____
How does your child tell you what s/he wants? _____

Check any areas of concern regarding Speech or Language:
Length of statements your child uses_____Ability to produce sounds correctly_____
Ability to find the right word_____ Stuttering of speech_____
Quality of voice (e.g. nasal, hoarse, pitch)_____
Ability to stay on topic_____ Ability to sustain attention_____
Ability to establish peer relationships_____Ability to follow directions_____
When did you first notice difficulties with your child's Speech or Language?_____
Does your child become frustrated due to these difficulties? _____
Family history of speech or language difficulties? Please describe _____
_____

Feeding

Does your child have any feeding difficulty with the following:
Poor Suck_____ Difficulty swallowing_____ Difficulty chewing_____ Gag/choke often_____
Finger feeding_____ Spoon use_____ Require a feeding tube_____ Reflux/vomiting_____
List any other feeding concerns_____
Is your child a picky eater? Y / N Does your child dislike particular textures of food? Y / N

Please describe_____

_____

Hearing/Vision

Has your child ever had a vision test? Y / N If yes, last date performed_____
Results_____
Does your child wear glasses? Y / N
Has your child ever had a Hearing test? Y / N If yes, last date performed_____
Results _____
Does your child wear a hearing aide? Y / N If yes, please indicate Left_____ Right_____

Sensory History:

Kids In Motion Therapy Clinic

4152 Meridian Street, Suite 105 PMB 159,

Bellingham, WA 98226

Do your child's hands, feet, and or tummy seem overly sensitive to touch? Y / N
Does your child seem distractible or hyperactive? Y / N If yes, please describe_____
_____

Does your child tolerate tooth brushing?	Yes	No
Does your child hesitate on uneven surfaces?	Yes	No
Does your child have difficulty positioning him/herself in a chair?	Yes	No
Does your child push/bump into other children?	Yes	No
Does your child seem generally weak?	Yes	No
Does your child have difficulty judging the height/depth of stairs?	Yes	No
Does your child walk/go down stairs heavily (stomping feet)?	Yes	No
Does your child have difficulty participating in sports with other children?	Yes	No
Does your child have a fear of using playground equipment (see-saw, swing)	Yes	No
Does your child have difficulty catching him/herself when falling?	Yes	No
Does your child not hear certain sounds?	Yes	No
Does your child respond negatively to certain sounds (running away, crying)?	Yes	No
Does your child seem to be a picky eater?	Yes	No
Does your child seem to always seek activities with pushing, pulling, jumping?	Yes	No
Does your child demand only to wear certain clothes all the time?	Yes	No
Does your child avoid getting hands messy?	Yes	No
Does your child get bothered by face washing/hair brushing?	Yes	No
Does your child spin, rock or hit self when distressed?	Yes	No
Does your child have difficulty keeping eyes on task/activity?	Yes	No
Does your child close one eye or tip head back when looking at something?	Yes	No

List any other concerns you would like to share with us regarding your child? His/her sensory processing, home or school skills that are not age appropriate.

_____

_____

What goal would you like your child to work on this year?

_____

_____

Do you have any questions for us?

_____

_____

Please list any behavioral Issues _____

Are their any behavioral strategies being used?

_____

_____

Please explain why you want this evaluation done: _____

_____

Has your child ever had any previous Evaluations/Therapy?	Yes	No

4152 Meridian Street, Suite 105 PMB 159,

Bellingham, WA 98226

If yes, please provide dates, Facility where performed, type of therapy and reason(s)

PHYSICAL	SPEECH	OCCUPATIONAL
_____	_____	_____
_____	_____	_____

Is there anything else that you would like us to know about your child?_____

_____

_____

Please list any pertinent family medical history: _____

_____

Educational History:

What school does your child attend? _____ Current grade level_____

How often does he/she attend school? _____ days per week____ hours per day_____

What are your child's strengths in school? _____

_____

_____

What areas at school are the most difficult for your child?_____

_____

_____

_____

_____

Thank you for taking the time to complete this form.
The information you have provided is valuable in assessing your child's developmental skills.

Patient Authorization

Release of Information & Consent for Treatment

All information provided herein is true and correct.

I am aware of my child's diagnosis and wish him/her to receive treatment at Kids In Motion Therapy Clinic. I permit its contractors and all other persons caring for my child to treat him/her in ways they judge are beneficial to him/her. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Kids In Motion Therapy Clinic to release information, verbal and written contained in my child's medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related health care provider, assignees and/or beneficiaries and all other related persons to my child's treatment or payment for services provided.

I understand that Kids In Motion Therapy Clinic also serves as a training facility and at times other therapists may be observing, handling, or have access to my child's medical information. I give my permission for Kids In Motion Therapy Clinic to use photographs and video taken of my minor child or myself during therapy sessions for educational, informational and promotional materials. I authorize Kids In Motion Therapy Clinic to obtain medical records and/or professional information from my child's physician or other medical professional as it relates to my child's treatment.

The signature below certifies that I have read and understand the above information. Initial:_____

4152 Meridian Street, Suite 105 PMB 159,

Bellingham, WA 98226

Payment Guarantee

I agree to pay Kids In Motion Therapy Clinic (KIMTC) for the services provided to my child or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my child's treatments unless agreed to in writing by myself and a representative of KIMTC

Parent/Guardian signature_____ Date:_____

Social Security # _____-_____-_____

FINANCIAL POLICY

Our staff verifies your insurance benefits prior to the onset of services as a courtesy to you. Although we strive to obtain the most accurate information possible, the quoted benefits from your insurance company are not a guarantee of payment. Should you need the detailed information about your coverage, please contact your insurance company directly.

You are responsible for you insurance deductibles, co-payments and supplies at the time of service.

In the event we receive a denial from your insurance company, and you choose to continue with therapy, payment is due on the 20th day of the month, in which services are provided.

If payment is not received from your insurance company within 60 days from the date of filing, you will be responsible for payment in full. We will supply any documentation requested by you insurance company to expedite payment. We accept cash, checks, Visa, MasterCard, and Discover.

There is a $25 service charge for all checks returned.

No shows will result in a $25 service fee, which will be due on the 20th day of the month.

If you request your therapy charges to be billed to party other than your insurance company, please provide the necessary billing information to our office. All billing directed to attorneys will have a lien placed on the account.

You are financially responsible for payment of services rendered. In the event the account becomes delinquent, and is therefore in default of payment, a collection fee will be added to the unpaid balance for the recovery of this debt.

If you have any questions or concerns regarding the financial policy, please speak to the Clinic Director or Patient Service Manager.

I understand that I am financially responsible to KIMTC for any changes incurred during the course of treatment and verification of benefits does not guarantee payment by the insurance company.

I hereby authorize payment be made directly to KIMTC.

_____ _____

Signature of Responsible Party Today's date

4152 Meridian Street, Suite 105 PMB 159,

Bellingham, WA 98226

OUTPATIENT CANCELLATION POLICY

Please make all efforts to be available for your child's Physical, Speech or Occupational therapy appointment on time. Your therapist has many people to see and makes every attempt to keep you on schedule. If you are unable to keep your appointment, please call and cancel so that we may adjust the therapist's schedule. We ask for at least a 24-hour notice for cancellations. We are aware that emergencies occur.

Should you miss an appointment with less than 24-hour notice or not show up for a scheduled appointment with no attempt to contact us, you will be charged $25.00 and further sessions will be suspended until we hear from you. If the therapist is unable to keep his/her appointment, you will be notified as soon as the therapist is aware and an alternate appointment will be made. Thank you in advance for your cooperation in this matter. Our mutual goal of providing quality therapy for your child can best be served if we all communicate changes in our schedules.

Please sign below to indicate awareness of this policy _____

Authorized Signature Today's date

WAIVER FORM

I, _____ the parent or guardian of _____ (thereafter referred to as "my child") give permission for my child to participate in Kids In Motion Therapy Clinic (KIMTC) programs and services.

I hereby release Kids In Motion Therapy Clinic, contractors, therapists, employees and representatives and all other individuals or organizations acting on behalf of Kids In Motion Therapy Clinic program, from any and all claims which I or my child may have, resulting from or in connection with my child's participation in KIMTC programs. This includes, but without limitation, any claim, demands or causes of action for injuries to my child, including but not limited to injuries resulting from the use of any play/ therapy equipment during the program at the KIMTC center or at clients homes.

I understand that I should be present at all times during delivery of service to my child. If I choose not to, I understand that the aforementioned statements still apply in my presence or absence during the services provided This agreement is signed for the purpose of fully and completely releasing, discharging and indemnifying KIMTC in connection with their programs from all liability as herein described.

Signed: _____

Parent or Guardian signature & printed name Date

Acknowledged By: _____

Kids in Motion Therapy Clinic Representative Date

4152 Meridian Street, Suite 105 PMB 159,

Bellingham, WA 98226

Notice of Privacy Practices **-- Acknowledgement**

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Nora Cohoe, Compliance Officer.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the HIPPA and/or Notice of Privacy Practices.

_____ _____

Signature of patient or authorized representative Date

_____ _____

Printed name if signed on behalf of patient Relationship (parent, legal guardian, personal representative, etc.)

(Notation, if any, by staff)

This form will be retained in your medical record.