



Therapy Intake Form

Thank you for your interest in our therapy services. To help better serve you, please provide us with the information requested below. Please be assured that the information you provide will be held confidential, and is necessary for our staff to determine and provide appropriate evaluation and therapy services.

Child's Information

Today's Date: _____

Child's Name: _____

Date of Birth: _____ Age: _____ Grade level: _____ Sex: M F

Diagnosis: _____ Age of diagnosis: _____

Please Specify all services you are interested in:

- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Feeding Therapy
- Sensory Integration Therapy
- Group Sessions

Referring physician: _____ Office Number: _____

How did hear about us?: _____

Main Concerns / Reason for Referral:

Please list 3 goals you would like to see your child achieve in therapy:

1. _____
2. _____
3. _____

Please list strong motivators for your child (favorite activities, toys, movies, foods, songs, etc.):

What are your child's biggest strengths? _____

What are your child's biggest struggles? _____

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Phoenix, AZ 85086

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Parent Contact Information

Primary Parent/Guardian name: _____

Relationship to the child: _____

Address: _____

City: _____ Zip code: _____

Email address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Please check which numbers we can leave a message: Cell Home Work

Preferred Contact Method (text/email/phone): _____

Employer: _____ Occupation: _____

Parent/Guardian name: _____

Relationship to the child: _____

Address: _____

City: _____ Zip code: _____

Email address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Please check which numbers we can leave a message: Cell Home Work

Preferred Contact Method (text/email/phone): _____

Employer: _____ Occupation: _____

Emergency Contact: _____

Name: _____ Phone: _____

Does your child have a case manager? Yes No

If yes, please provide his/her name, agency and contact information:

Please list who lives with the child:

Name: _____ Sex: M F Age: _____ Relationship: _____

Name: _____ Sex: M F Age: _____ Relationship: _____

Name: _____ Sex: M F Age: _____ Relationship: _____

Name: _____ Sex: M F Age: _____ Relationship: _____

Please specify living and visitation arrangements if the child is not living with both biological parents:

Specify who has legal custody: _____

What languages are spoken in the home: _____

Please specify any cultural factors that need to be accommodated as part of your child's treatment:

Medical History

Birth History: Biological Child Adopted Foster Child
Weeks' Gestation: _____
Delivery: Vaginal C-section Reason for C-section: _____
Weight at birth: _____
Complications during pregnancy: No Yes If yes, please describe:

Complications at birth: No Yes *Please Describe:*

After birth, how long was your child in the hospital before discharge: _____
Any supportive care provided while in the hospital before discharge: _____
Describe any health problems or illnesses during the first 2 weeks of life:

Did your child pass their newborn hearing screen: No Yes
Has your child's hearing been formally retested since birth? No Yes
If yes, please indicate by whom, date and results:

Does your child wear glasses: No Yes
Has your child's vision been formally tested? No Yes
If yes, please indicate by whom, date and results:

Do you have any concerns with your child's hearing or vision? No Yes
If yes, please explain:

Pertinent Medical History (If checked, please explain, and include approximate age)

- Chronic Ear infections _____
- Ear tubes _____ Were tubes ever recommended? No Yes
- Childhood illnesses _____
- Frequent strep throat, colds, or respiratory viruses _____
- Mental health issues _____
- Physical disability _____
- Head injuries _____
- Asthma _____
- Tonsillectomy _____
- Adenoidectomy _____



- ER visits _____
- Overnight hospitalizations _____
- Surgeries or procedures _____
- Seizures _____
- Allergies (food, environmental, latex, meds, etc.) Is your child anaphylactic? No Yes
Please list and explain: _____
- Previous orthopedic injuries _____
- Genetic disorder _____
- Restrictive diet _____
- Reflux (GERD) _____

Previous or current therapy services/Where/When/Duration

*Please provide any recent evaluation and/or progress reports

Other

Developmental History

Please give approximate age ***in months*** when your child reached the following milestones:

Rolled both directions: _____

Able to sit alone: _____

Crawled: _____

Walked: _____

Babbled: _____

Said first word: _____

Put 2-3 words together meaningfully: _____

Toilet trained: _____

At what age, did you *first* become concerned about your child's development? _____

Does your child use any adaptive equipment or augmentative communication device? No Yes

If yes, please explain

Other developmental concerns (If checked, please explain and include approximate age)

Difficulty latching onto breast or bottle as infant _____

Difficulty transitioning to solid food _____

Excessive drooling _____

Overstuffs mouth with food _____

Coughs, gags, or chokes when eating _____

Gagging during feeding with only sight or smell _____

Avoids certain food tastes/textures _____

Difficulty chewing food _____

Fussy eater _____

If yes, what will your child eat willingly? _____

If yes, what does your child refuse to eat? _____

Often bites, chews, licks non-edible objects _____

Gets upset if food gets on his/her hands _____

Appears to have weak arms, legs or trunk _____

Body appears "floppy" _____

Body appears "stiff" _____

Seems uncoordinated compared to same age peers _____

Clumsy (trips, falls, bumps into things) _____

Difficulty climbing stairs _____

Poor balance _____

Unable to catch a ball _____

Unable to kick a ball _____

Walks on toes _____

- Sits on floor with legs in a “W” position _____
- Delayed in developing motor milestones _____
- Weak hands _____
- Poor pencil grasp _____
- Difficulty with handwriting _____
- Difficulty dressing self or using feeding utensils _____
- Easily distractible _____
- Difficulty attending to a task until completion _____
- Irrational fears _____
- Extreme fear of movement when roughhousing (cries, clings to adult) _____
- Fear of slides, swings and playground equipment/overly cautious _____
- Little regard for safety/ takes excessive or dangerous risks _____
- Always “on the go” / difficulty with seated/structured tasks _____
- Seems “too rough”/ crashes into furniture, jumps off things, rough with other kids, breaks things _____
- Unconsciously spins or rocks self _____
- Bangs head _____
- Distress with touching certain textures _____
- Distress with being touched, hugged, kissed _____
- Distress wearing certain clothing _____
- Distress with getting hands messy/dirty _____
- Distress with bath (especially having hair washed) _____
- Distress with hair and teeth brushing _____
- Excessively likes to touch people or objects _____
- Eager to get messy / dirty and will often wipe all over self _____
- Distress with loud or unexpected noises (vacuum, blender, sirens, dogs barking, etc.) _____
- Distress with loud environments (parties, kids play areas, restaurants, people talking) _____
- Covers ears _____
- Have extreme tantrums that last a very long time _____
- Once he/she gets upset they have a very difficult time calming back down/inconsolable _____
- Behavioral problems _____
- Self-injurious behaviors _____
- Aggression towards adults, other children or property _____
- Academic problems _____
- Has poor sleep habits / poor sleep routine _____
- Difficulty “going with the flow” when routine changes _____
- Difficulty transitioning from one activity to another / will have tantrums _____
- Difficult time interacting with other children/plays mostly by himself/herself _____
- Doesn’t seem to understand social cues _____
- Makes little eye contact _____
- Difficulty engaging in purposeful play with toys and others _____
- Limited pretend play _____
- Fixates on TV / Tablet / Smart phone _____

- Lines up toys/has difficulty playing with its intended purpose _____
- No verbal language _____
- Has limited vocabulary _____
- Hard to understand your child _____
- Echolalia (repeats common words/phrases) _____
- Did your child ever lose words or language skills? What age? _____
- Does your child attempt speech and then get mad when people don't understand him/her _____

Education History

Please list all current and past schools your child has attended and any services received?

School Names	Dates of attendance	Grade Completed	Services Received
_____	_____ to _____	_____	_____
_____	_____ to _____	_____	_____
_____	_____ to _____	_____	_____
_____	_____ to _____	_____	_____



Authorizations

Authorization and Consent for Treatment

I consent to and grant permission to the employees of North Valley Pediatric Therapy to render to my child routine clinical care including evaluations, educational services, and therapy activities/procedures during my receipt of services. I also acknowledge that North Valley Pediatric Therapy has not made any guarantee or warranty as to the result of any services or treatments given.

Authorization Signature: _____ Date: _____

I understand that checking this box constitutes a legal electronic signature confirming that I acknowledge and agree to the above Terms of Acceptance.

Consent to Bill Health Insurance

North Valley Pediatric Therapy is considered in-network for most major insurance carriers and considered out-of-network for all insurance plans. If you have out-of-network benefits with your insurance plan, it may be possible to be reimbursed by your insurance company for therapy services.

North Valley Pediatric Therapy will verify benefits only upon the initial evaluation/treatment session. Verification of benefits is not a guarantee of coverage or payment and all insurance payments are subject to medical necessity and eligibility at the time services are rendered. I understand that an office visit and specific therapy charges are incurred at each appointment. Knowledge of maximum number of visits, deductible amounts and out of pocket maximums are your responsibility. Co-pays, deductibles and coinsurance are due at the time of service. It is your responsibility to update us on any changes made to your insurance.

Questions regarding insurance claims or payments should only be directed to the billing department of North Valley Pediatric Therapy and not to treating therapists.

I consent for North Valley Pediatric Therapy, including its providers to bill my private health insurance. I also consent to the release of any information necessary to file a claim with my health insurance plan.

Authorization Signature: _____ Date: _____

I understand that checking this box constitutes a legal electronic signature confirming that I acknowledge and agree to the above Terms of Acceptance.

Will you be filing with your insurance company? Yes No

Primary Insurance:

Insurance name: _____ Health Plan, if Applicable: _____
Member's name (Policy holder): _____ Member's date of birth: _____
Member's relationship to child: _____
Member's Employer: _____
Member ID#: _____ Group Policy#: _____ Effective Date: _____
Insurance phone #: _____

Secondary Insurance:

Insurance name: _____ Health Plan, if Applicable: _____
Member's name (Policy holder): _____ Member's date of birth: _____
Member's relationship to child: _____
Member's Employer: _____
Member ID#: _____ Group Policy#: _____ Effective Date: _____
Insurance phone #: _____

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****Please include front/back copies of all insurance cards**

Email info@nvpediatrictherapy.com for questions regarding insurance and other payment options.

Credit Card Authorization

North Valley Pediatric Therapy requires that we have a credit card on file for all clients. Client authorizes North Valley Pediatric Therapy to charge any outstanding balances to the credit card number provided. We will contact you before charging a balance over \$250. Client agrees that all information provided is accurate and complete.

Name on Card: _____

Patient (child) name: _____

Credit Card Type: Visa MC AMEX Discover

Credit Card Number: _____

CVC Number: _____

Expiration Date: _____

Email address for receipt: _____

Billing address: _____

State: _____ Zip code: _____

Phone number: _____

Authorization Signature: _____ Date: _____

I understand that checking this box constitutes a legal electronic signature confirming that I acknowledge and agree to the above Terms of Acceptance.



Consent for Client Pictures

As a whole, North Valley Pediatric Therapy would like to periodically feature clients and celebrate their successes by sharing their experiences in the clinic. The law requires that we ask for your permission to use these types of images of your child, but more importantly, we only wish to celebrate your child in an environment that is comfortable for both you and them.

Pursuant to law, we will not release any personally identifiable information without prior written consent from you as parent or guardian. Personally identifiable information includes name, address, email address, or phone number.

If you, as parent/guardian, wish to rescind this agreement, you may do so at any time in writing, which will take immediate effect upon receipt by North Valley Pediatric Therapy.

I grant permission for a photo/image that includes my child, without any other personal identifiers, to be published on the North Valley Pediatric Therapy website/Facebook/Instagram.

I DO NOT grant permission for a photo/image that includes my child, without any other personal identifiers, to be published on the North Valley Pediatric Therapy website/Facebook/Instagram.

Child's Name: _____

Guardian/Parent: _____

Relationship to child: _____

Authorization Signature: _____ Date: _____

I understand that checking this box constitutes a legal electronic signature confirming that I acknowledge and agree to the above Terms of Acceptance.

Appointment Reminders

North Valley Pediatric Therapy sends appointment reminders via text and/or email 24 hours prior to your scheduled appointment. This is an automatic service and is recommended.

I, _____, hereby authorize "North Valley Pediatric Therapy" to send me an appointment reminder via e-mail or text message using the following information.

Email reminders may contain patient or clinic information.

E-mail: _____

Cell phone: _____

Authorizing Signature: _____ Date: _____

I understand that checking this box constitutes a legal electronic signature confirming that I acknowledge and agree to the above Terms of Acceptance.



Release and Exchange of Information

*If you are using insurance to pay for services, we must have contact information and permission to exchange information with your child’s primary physician prior to initiating services.

Please list all specialists involved in your child’s care (all doctor’s, schools, therapy services etc.)

Profession: Physician/Pediatrician

Name _____ Phone _____ Fax _____

Address _____

Specialist: _____

Name _____ Phone _____ Fax _____

Address _____

Specialist: _____

Name _____ Phone _____ Fax _____

Address _____

Name of child: _____ Date of Birth: _____

Name of parent(s) or Guardian: _____ Phone: _____

____ If you are separated or divorced, please verify you are the party above and have legal custody by initialing

I give permission for North Valley Pediatric Therapy to release and/or exchange information with the professionals whom I have identified. I authorize North Valley Pediatric Therapy to release and/or exchange information with my insurance provider(s).

Parent/Guardian Authorization Signature: _____ Date: _____

I understand that checking this box constitutes a legal electronic signature confirming that I acknowledge and agree to the above Terms of Acceptance.

Acknowledgement of Notice of Privacy Practices

I have read and understand the Notice of Privacy Practices found on nvpediatrictherapy.com under Getting Started.

Authorization Signature: _____ Date: _____

I understand that checking this box constitutes a legal electronic signature confirming that I acknowledge and agree to the above Terms of Acceptance.



Checklist

*Please check that all items are completed before submitting your intake packet to ensure a faster enrollment process.

- Completed Intake Packet
- Copy front and back of all insurance cards
- Recent therapy evaluations and/or progress reports
- Signature/date for Authorization and Consent for Treatment
- Signature/date for Consent to Bill Health Insurance
- Signature/date for Credit Card Authorization
- Signature/date for Consent for Client Feature
- Signature/date for Appointment Reminders
- Signature/date for Release and/or Exchange of Information
- Information of all specialists involved in your child's care
- Signature/date for Acknowledgement of Notice of Privacy Practices
- All Electronic Acknowledgement Signature Boxes are checked (if sending signed electronically)