FUNCTIONAL KIDS THERAPY

every child deserves a champion

Outpatient Pediatric Intake Form

Child's Name: _____ Nickname:_____DOB: _____ Age: _____

M/F: _____ Current Diagnosis: _____

Address:_____ City:_____ State: ____ Zip Code: _____

Primary Phone: _____ Preferred E-mail: _____

Child's School: _____ Grade: _____

Parent #1 Name: _____ DOB:_____ Occupation: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

SS #:_____ Marital Status: M S W D (please circle one)

Parent #2 Name: _____ DOB:_____ Occupation: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

SS #:_____ Marital Status: M S W D (please circle one)

Non Parental Emergency Contact: _____ Relationship: _____ Phone:_____

Primary Language: _____ Language(s) Spoken at Home: _____

Child's Primary Physician: _____ Address/Phone: _____

Child's Referring Physician: _____ Address/Phone: _____

Reason for Referral: _____

What are your primary areas of concern? What are you hoping for the therapist to address?

_____

_____

_____

_____

What are your goals for therapy?

_____

_____

_____

_____

Please list any medical precautions, allergies, supplements and/or medications:

_____
_____
_____
_____

Is your child receiving any other services (i.e. counseling, ABA, special education, early intervention)?

_____
_____
_____
_____

What (if any) special equipment does your child use?

□ Wheelchair □ Eyeglasses □ Hearing Aids □ Orthotics □ Braces □ Walker □ Communication Device

□ Crutches □ Other: _____

Prenatal & Birth History:

Full-term	□ Yes □ No
Premature	□ Yes □ No If yes, how many weeks gestation? _____
Low birth weight	□ Yes □ No
Birth weight	____lb(s)____oz
Breech birth	□ Yes □ No
Type of delivery	□ C-section □ Vaginal If C-section, was it an emergency? □ Yes □ No
Forceps assisted	□ Yes □ No
Vacuum assisted	□ Yes □ No
Preeclampsia	□ Yes □ No
Gestational diabetes	□ Yes □ No
Multiple ultrasounds	□ Yes □ No
Oxygen deprivation	□ Yes □ No
NICU stay	□ Yes □ No If yes, what was the duration? _____

Please list any other significant prenatal or birth history:

_____
_____
_____
_____

Medical & Developmental History:

Jaundice	□ Yes □ No
Breast fed	□ Yes □ No
Formula fed	□ Yes □ No
Poor suction/latch	□ Yes □ No
Chronic ear infections	□ Yes □ No
Tubes	□ Yes □ No
Tonsils/adenoids surgery	□ Yes □ No
Acid reflux	□ Yes □ No
Poor weight gain	□ Yes □ No
Feeding problems/picky eating	□ Yes □ No
Tongue or lip tie	□ Yes □ No
Colic	□ Yes □ No
Sleeping problems	□ Yes □ No
Asthma	□ Yes □ No
Cardiac issues	□ Yes □ No
Frequent antibiotic use	□ Yes □ No
Frequent fevers	□ Yes □ No
Abnormal muscle tone	□ Yes □ No
Vision problems	□ Yes □ No
Compromised immune system	□ Yes □ No
Headaches	□ Yes □ No
Abnormal lab results	□ Yes □ No
Hearing problems/evaluation	□ Yes □ No
Allergies	□ Yes □ No
Wetting	□ Yes □ No If yes, day or night? _____

Please list any other significant medical history including significant illnesses, hospitalizations, or surgeries:

_____
_____
_____
_____

Check the statement that best describes your child:

□ Didn't like tummy time	OR	□ Loved being on belly
□ Met all motor milestones on time	OR	□ Was/is developmentally delayed
□ Is clumsy	OR	□ Has always seemed athletic
□ Struggles with use of hands/fine motor	OR	□ Uses utensils and pencils easily
□ Avoids climbing, swinging, being upside down	OR	□ Seems to crave/love movement

When did your child do the following?

Skill	***Age (months)***
Sat up	
Rolled over	
Pulled up to stand	
Belly crawled	
Hands and knees crawled	
Walked	
Spoke first word	
Spoke in sentences	

My child communicates using:

□ is non-verbal
□ single words
□ 2-3 word phrases
□ sentences

Please list any motor development concerns you have (i.e. gross motor, fine motor, oral motor, motor planning, fear of movement, fear of heights, etc.):

_____
_____
_____

Academic History:

Check all that applies to your child:

□ Does well in school
□ Does well with the exception of:_____
□ Is challenged by school
□ Is challenged by writing
□ Is challenged by reading comprehension
□ Is challenged by decoding
□ Receives intervention/tutoring for:_____
□ Has an IEP/IFSP
□ Is in a self-contained classroom

Describe your child's grades in school (Letter grades, areas of strength/weakness, etc.):

_____
_____

Please list any academic concerns you have:

_____
_____
_____
_____

Please list any concerns your child's teacher has mentioned:

_____
_____
_____

Behavior/Social History:

Check all that applies to your child:

□ Is social and engaging
□ Makes good eye contact with adults and peers
□ Is well behaved
□ Pays attention
□ Listens well
□ Follows directions well
□ Plays well with other children
□ Is easy going
□ Does well with change
□ Understands safety
□ Takes turns with peers
□ Is aggressive
□ Is oppositional
□ Does not like new places/people
□ Does not like crowds
□ Has difficulty with transitions
□ Prefers to play alone
□ Has difficulty paying attention
□ Has difficulty listening
□ Is very busy and active
□ Poor coping skills
□ Unable to self-calm
□ Extremely sensitive to criticism
□ Quickly escalates without apparent cause
□ Has tantrums

Please list any other behavioral, emotional, or social concerns:

_____
_____
_____

Evaluation & Therapy Services:

Please list any previous occupational, speech, or physical therapy evaluations completed and recommendations:

_____
_____
_____
_____

Please list any previous psychological/neuropsychological/psychoeducational evaluations completed and recommendations:

_____
_____
_____
_____

Functional Kids and Parent/Guardian Conduct Policy

By signing below all guardians and parents are agreeing to adhere to the **FUNctional Kids** Conduct Policy which prohibits the use of any and all negative behaviors to intimidate, harass, belittle or threaten staff members in this place of business. Any violations with the above mentioned behaviors are grounds for immediate dismissal from therapy services. Be advised that any extreme situation experienced by a staff member can be immediately reported to the local authorities and your child's care will be immediately terminated from our practice without verbal or written advanced warning.

Parent /Guardian signature:_____Date: _____

Functional Kids Insurance Policy

You are responsible for knowing your benefits outlined in your specific insurance plan including your co-insurance, co-pay, and deductible amounts if applicable. Please be advised that many insurance providers do not cover therapy due to most developmental disorders. Functional Kids Therapy Center LLC is NOT responsible for these costs that are dictated by your insurance carrier and if coverage is denied you will be responsible for payment of care, including any evaluations.

Should you be delinquent in paying your bill past 3 months and have not made arrangements for a payment schedule, you are legally responsible for the amount outlined by your insurance carrier and will be sent to collections if the account goes unpaid. You are responsible for any finance charges & fees **Functional Kids Therapy Center LLC** incurs in collecting therapy service fees from you including legal costs for actions that may be needed to collect on you account(s).

My signature below is confirmation that I have been informed of and agree to the insurance policy of **Functional Kids Therapy Center LLC.**

Insurance Information: *please list all active policies.*

Primary Insurance:_____
Subscriber: _____
Subscriber Date of Birth: _____
Relationship to client: _____
Contract/ID#: _____
Group #: _____
Employer: _____

Secondary Insurance: _____
Subscriber:_____
Subscriber Date of Birth:_____
Relationship to client: _____
Contract/ID#: _____
Group #: _____
Employer: _____

I, _____, hereby give my consent for Functional Kids Therapy Center LLC to bill my/my child's insurance carrier for the services rendered to me/my child/family by the above mentioned provider. In addition, I agree to pay Functional Kids Therapy Center LLC any remaining fees or uncovered charges in accordance with my health care plan. **Although we do check the billing codes provided to us from the referring providers prior to an appointment; this does not guarantee payment or coverage. It is your responsibility to know your benefits, copays and deductible.**

_____ _____ _____
Parent/Guardian Signature | Relationship to client | Date

Consent To Treat

Patient Name:_____ Date of Birth:_____

1. **Consent for Evaluation and Treatment** - I hereby give my consent for my child/dependent to receive occupational therapy, physical therapy, and/or speech therapy services at Functional Kids Therapy Center LLC. I understand that:
   - The purpose of therapy services is to evaluate and/or treat physical, cognitive, communication, or functional conditions.
   - Treatment may include hands-on techniques, therapeutic exercises, assistive devices, and activities designed to improve function.
   - The treatment plan will be developed based on the evaluation findings and discussed with me.
   - I have the right to ask questions and participate in the planning of care at any time.
   - Services may be provided in person or via telehealth, if appropriate and agreed upon.

2. **Risks and Benefits** - I understand that, while therapy often leads to improvement in function and quality of life, there is no guarantee of outcomes. I understand the therapists will take all reasonable precautions to ensure my child's safety. Potential risks include, but are not limited to:
   - Temporary increase in pain, soreness, fatigue, or discomfort
   - Emotional responses due to the nature of communication or behavioral therapy
   - Reactions to equipment or techniques used

3. **Confidentiality** - All sessions are confidential in accordance with HIPAA and state laws, except where disclosure is required by law.

4. **Rights**- I understand that I have the right to refuse or withdraw my consent for therapy at any time, and that such refusal or withdrawal will not affect my access to future care or services.

5. **Acknowledgment and Agreement** - By signing below, I acknowledge that I have read and understood the consent form. I have the opportunity to ask questions and voluntarily consent to receive therapy services for my child/dependent.

Parent/Guardian Signature: _____ Relationship to Patient:_____
Date:_____