



INTAKE FORM

PLEASE FILL OUT EVERY SECTION POSSIBLE • *RED HIGHLIGHTED AREAS ARE REQUIRED

5000 Research Ct.
Ste 450
Suwanee, GA 30024
Phone: (770) 205-5551

PATIENT & FAMILY INFORMATION

* Patient's Name _____

Parent's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Cell _____ Work _____

E-mail _____

Emergency Contact Name _____ Emergency Contact Phone _____

PATIENT SPECIFIC INFORMATION

Male Female

Date of Birth _____

Diagnosis _____

Patient Lives with:

Mother Father Both Other

Today's Date _____

PRIMARY INSURANCE INFORMATION

Primary Insurance _____

Street Address _____

City _____ State _____ Zip Code _____

ID# _____ Group # _____

Guarantor's Name _____ Guarantor's Social Security# _____

Guarantor's Date of Birth _____ Guarantor's Relation to Patient _____



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SECONDARY INSURANCE INFORMATION

Secondary Insurance _____

Street Address _____

City _____ State _____ Zip Code _____

ID# _____ Group # _____

Guarantor's Name _____ Guarantor's Social Security# _____

Guarantor's Date of Birth _____ Guarantor's Relation to Patient _____

MEDICAID INFORMATION

Medicaid # _____ Status _____

PEDIATRICIAN INFORMATION

*Referring Pediatrician _____

Street Address _____

City _____ State _____ Zip Code _____

Other Referral Source Name _____ Phone # _____

OTHER PHYSICIAN/SPECIALIST/PROFESSIONALS YOUR CHILD WORKS WITH

Other Referral Source _____ Phone # _____

Other Referral Source _____ Phone # _____

Other Referral Source _____ Phone # _____

FAMILY BACKGROUND

Mother's Name _____ Age _____

Occupation _____ Education Level _____

Father's Name _____ Age _____

Occupation _____ Education Level _____



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EDUCATION INFORMATION

Is your child currently enrolled in school? YES NO

If "YES" where and what days _____

*Does your child receive any services through the school? YES NO

If "YES" what services? _____

*Does your child have a current Individualized Education Plan (IEP)? YES NO

* Please bring IEP 1st-visit

OVERVIEW OF NEEDS, CHALLENGES & GOALS

Describe your concerns and nature of the problem:

What are your goals for your child?

1) _____

2) _____

3) _____



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BIRTH & INFANCY RECORD

Hospital _____ Birth Weight _____

Was patient delivered: Premature Full Term Post Mature

Describe if needed _____

Any complications during pregnancy: Illness Infection Stress

Describe if needed _____

Any Complications During Labor and Delivery? _____

Difficulty in Nursing and/or Bottle Feeding?

As an infant did the child seem: (check answers that apply) _____

- | | | |
|------------------|---------------------|---------------------------|
| happy | difficult to soothe | like being rocked |
| cry frequently | wake often | fuss when held |
| sleep long hours | feed slowly | difficult to hold/cuddle |
| colicky | eat well | difficult to get to sleep |

DEVELOPMENTAL MILESTONES Please note approximate age at which he/she did the following:

Sat _____ Belly Crawled _____

Crawled _____ Cruised _____

Walked _____

Said first words _____ Putting 2-3 words in sentences _____

Toilet trained: Bladder _____ Bowel _____

Managed fasteners _____ Tied shoelaces _____

Preferred hand: Right Left Both

What age established _____



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MEDICAL HISTORY

Injuries/Hospitalizations: _____

Describe if needed

Ear infections: YES NO How often _____

Allergies: Food Skin Respiratory Describe allergy types:

Seizures: YES NO What type of seizures: _____

Most recent eye exam date: _____

Most recent hearing examination date: _____

Results _____

Has your child ever been diagnosed with auditory processing disorder?: YES NO

MEDICATION

CONDITION BEING TREATED

Name: _____ Condition: _____

Name: _____ Condition: _____

Name: _____ Condition: _____

Name: _____ Condition: _____

Name: _____ Condition: _____

Name: _____ Condition: _____



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MOTOR DEVELOPMENT (can your child perform the following)

SKILLS	YES	NO	FAIR	AVERAGE	GOOD
Sit					
Crawl					
Walk					
Run					
Drink with cup					
Eat with utensils					
Tie shoelaces					
Jump with both feet together					
Ride Tricycle					
Ride a bicycle (training wheels on/off)					
Pump self on swing					
Kick a ball					
Cut with scissors					

SPEECH & LANGUAGE DEVELOPMENT

How many words does your child use at this time to communicate:

0-10 10-20 20-50 50-100 >100

How does your child communicate his/her wants and needs?

pointing signing gestures sounds words communications device

Please describe any other concerns/goals regarding speech and feeding development:

Does your child experience any sucking, chewing, choking or swallowing problems? yes no

Does your child mouth inedible objects upon presentation? Please describe



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PLAY SKILLS AND SOCIALIZATION

What toys/activities are your child's favorite?

What activities does your child least enjoy?

Does your child tend to line or pile up toys?

Whom does your child prefer to play with?

Describe your child's strength and personality.

Please describe any concerns/goals regarding your child's socialization or play skills:

ACTIVITIES OF DAILY LIVING

Describe your child's independence in activities of daily living (mark which one describe your child best)

Unable Assistance Supervision Independent

Dresses self	
Undresses self	
Brushing teeth	
Toilets self	
Washes hands	
Puts shoes on	
Ties shoelaces	
Manipulating fasteners (i.e. buttons, zippers)	
Feeds self	
Eat with utensils	
Drinks from a cup	



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PROPRIOCEPTIVE			
	loves to be held tightly		seeks pressure on his body
	breaks toys, squeezes objects		crashes into things (on purpose)
	pushes too hard on objects		loves to jump

AUDITORY (sound)			
	over-sensitive to loud sounds		diagnosed with speech problem
	likes to make loud sounds		diagnosed with hearing problem
	misses sounds, difficulty following directions		

REGULATORY			
	easily distracted		short attention in group activity
	difficulty with bowel/bladder training		dislikes changes in routine
	difficulty with sleep patterns		unusually high energy level
	problems with appetite control		unusually low energy level

VESTIBULAR (movement)			
	poor posture		tires easily
	poor strength and endurance		often props head on hand at table

ORALAND GUSTATORY			
	unaware of flavors, taste		over-sensitive to taste, flavors
	eats a limited variety of foods		over-sensitive to temperature
	explores objects first by smell		over-sensitive to smells
	difficulty recognizing odors		reacts negatively to certain foods
	unaware of noxious odors		dislikes carbonated beverages



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SENSORY PROCESSING

(Please mark with a check those items that currently describe your child. Feel free to add items that you think are related so that they can be discussed with the therapist.)

TACTILE			
<input type="checkbox"/>	dislikes having teeth brushed	<input type="checkbox"/>	seems over-sensitive to unexpected touch
<input type="checkbox"/>	dislikes dental visits	<input type="checkbox"/>	avoids physical affection unless self-initiated
<input type="checkbox"/>	dislikes wearing socks/shoes	<input type="checkbox"/>	constantly seeks to touch people or things
<input type="checkbox"/>	dislikes having face washed	<input type="checkbox"/>	needs to hold objects in hand
<input type="checkbox"/>	dislikes hair combing	<input type="checkbox"/>	excessively mouth objects or chews clothes
<input type="checkbox"/>	dislikes the feeling of new clothes	<input type="checkbox"/>	bangs head intentionally
<input type="checkbox"/>	wants tags in clothes cut out	<input type="checkbox"/>	overreact to getting hurt
<input type="checkbox"/>	dislikes having feet touched	<input type="checkbox"/>	under-react to getting hurt
<input type="checkbox"/>	dislikes having hand held	<input type="checkbox"/>	becomes impatient/disruptive standing in line
<input type="checkbox"/>	dislikes seams in clothing/socks	<input type="checkbox"/>	seem excessively ticklish
<input type="checkbox"/>	has strong clothing preferences	<input type="checkbox"/>	frequently bumps/pushes/fights with others
<input type="checkbox"/>	dislikes elastic in sleeves/waist	<input type="checkbox"/>	dislikes long sleeves, high necklines
<input type="checkbox"/>	dislikes wearing shorts/bathing suit	<input type="checkbox"/>	over or under dress for temperature
<input type="checkbox"/>	dislikes playing with messy materials	<input type="checkbox"/>	dislikes baths or showers
other (please describe):			



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AUTHORIZATION

I hereby authorize the release of any medical or other necessary information to Kidz Therapy Networks LLC, I also authorize payment of medical benefits to Kidz Therapy Networks LLC for services rendered. I further agree that should the amount be insufficient to cover the entire expense, I will be responsible for payment of the entire bill.

Medicare/ Medicaid Lifetime Signature on file:

I request that payment of authorized Medicaid benefits be made on my behalf to Kids Therapy Networks Services for any services furnished to me by the therapist. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

(by filling in your name constitute a signature)

*Signature _____

*Date _____

AUTHORIZATION

By signing this I hereby affirm that to the best of my knowledge and belief I have provided complete, truthful and honest answers to the questions herein.

(by filling in your name constitute a signature)

*Signature: _____

Please fill out every field possible so we can best evaluate the patient's needs and provide the services that will best advance your needs and goals. Fields marked with * are required.

*Relationship to Child: _____ *Date: _____