kidz THERAPY NETWORKS

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INTAKE FORM

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

5000 Research Ct.
Suite 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 _____

Dlagnosis _____

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 _____

Preffered 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	◯	◯	◯	◯	◯
Rade 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 enjoys?

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

☐	dislikes having teeth brushed	☐	seems over-sensitive to unexpected touch
☐	dislikes dental visits	☐	avoids physical affection unless self-initiated
☐	dislikes wearing socks/shoes	☐	constantly seeks to touch people or things
☐	dislikes having face washed	☐	needs to hold objects in hand
☐	dislikes hair combing	☐	excessively mouth objects or chews clothes
☐	dislikes feeling of new clothes	☐	bangs head intentionally
☐	wants tags in clothes cut out	☐	overreact to getting hurt
☐	dislikes having feet touched	☐	under-react to getting hurt
☐	dislikes having hand held	☐	becomes impatient/disruptive standing in line
☐	dislikes seams in clothing/socks	☐	seem excessively ticklish
☐	has strong clothing preferences	☐	frequently bumps/pushes/fights with others
☐	dislikes elastic in sleeves/waist	☐	dislikes long sleeves, high necklines
☐	dislikes wearing shorts/bathing suit	☐	over or under dress for temperature
☐	dislikes playing with messy materials	☐	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, Inc., Mind & Motion and their business associates. I also authorize payment of medical benefits to Kidz Therapy Networks, Inc. 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: _____

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