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 #:_____

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

Home Phone: _____Cell Phone: _____ Work Phone: _____

SS #:_____

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? _____

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 prenatal or birth history:

_____
_____
_____
_____

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:

_____
_____
_____
_____

I would like to receive appointment reminders via text. □ Yes □ No

I consent to electronic communication with Functional Kids including but not limited to requests for electronic billing statements, evaluation reports, and/or progress notes. □ Yes □ No

If yes, preferred e-mail: _____

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 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 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 your 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.

Parent/guardian signature: _____ Date:_____

FUNctional Kids Attendance Policy

FUNctional Kids Therapy Center wants to improve your child's quality of life through consistent and high quality care. Cancellations, especially those with less than 24 hour notice including no-call/no-shows limit your child's progress and our ability to care for others. Please call the Battle Creek location at (269) 223-7789 or the Caledonia location at (616) 536-2211 if you need to cancel or reschedule an appointment. We ask for your full cooperation with the following policy:

- If you are unable to keep your scheduled appointment, we request that you notify us immediately so that your appointment can be rescheduled and another patient may take your slot. **You must cancel by noon the previous business day to avoid a $25 cancellation fee.**
- Greater than 50% cancellation in a 30 day period will also result in loss of preferred afternoon or early morning time slot(s) until further consistent attendance is established.
- **If you do not show up to a scheduled appointment, a $50 no-show fee will be added to your account and must be paid before resuming therapy.** All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payer.
- If you accumulate two no-shows this will result in an automatic discharge and physician notification.

We believe that this policy is necessary for the benefit of all patients, so that we can continue to provide high-quality treatment and service to everyone. If you should have any questions regarding this policy, please feel free to discuss them with your therapist.

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

Parent/guardian signature: _____ Date:_____

Release of Information Agreement

I, _____the parent/guardian of _____
(Parent's/guardian's name) (Child's name)

agree to allow FUNctional Kids Therapy Center **to release and/or receive information** regarding my child to/from the following providers or facilities:

_____

_____

_____

_____

This may include but is not limited to the use/exchange of written, electronic, verbal information to assist this center and other providers in the care of my child. I understand that this information cannot be exchanged without my written consent and hereby give approval for these acts between providers to occur. Secured servers and HIPAA privacy policy will be maintained during these actions to protect the client's identity and will be top priority at all times.

Printed Name of Parent/guardian:_____ Date:_____

Signature of Parent/guardian:_____ Date:_____