Occupational Therapy Intake Packet

Name: ________________________________ M/F: ________________
Preferred to be called: _____________________ Diagnosis: ____________
Date of Birth: ______________________________ Age:_____________
Address: ____
City ____________________ State ________________Zip__________

Father/Guardian's Information
Name: ______________________
Address (if different): ____________
____
Home phone: ________________
Work phone: ________________
Cell phone: _________________
Email address: ______________
Preferred method of contact: _______
Age: _____ Occupation: __________

Mother/Guardian's Information
Name: ______________________
Address (if different): ____________
____
Home phone: ________________
Work phone: ________________
Cell phone: _________________
Email address: ______________
Preferred method of contact: _______
Age: _____ Occupation: _________

Persons currently living in home environment (siblings and ages, grandparents, etc):
____

Childs School: ______________________ Grade: __________________
Teacher's Name: ____

Primary Physician: ____
Specialists: ____
Reason for OT referral: ____

Parent's concerns are: ____
____
Parent's goals for OT: ____
____

2751 Green Oaks Road Fort Worth, TX 76116
www.hopecenter4autism.org
Phone) 817-560-1139

Birth History:

Was child born full term? ____

If not, how many weeks gestation? __________ Birth Weight: ________________

	Yes	No	Comments
Complications during delivery?			
Did child require NICU hospitalization?			
Have feeding problems as a newborn?			
Have surgery as a newborn?			

Developmental Milestones:

Indicate child's age for achieving the skill. If uncertain, indicate early, late, or typical:

_____ Independent sitting _____ hands/knees crawling _____ walking

_____First words _____ sentences _____ toilet trained

Do you think that any part of your child's development is faster or slower than average?

________ If yes, explain: ____

Current areas of concern (please mark all that apply):

____Gross Motor Development ____Sleeping ____Social Skills

____ Fine Motor Development ____Play Skills ____Eating

____Language Development ____Temperament ____Self-Help Skills

____ Other (Please List)

When did you first notice your child's difficulties and how were they apparent to you?

Is there a family history of similar difficulties? If so, who, and what are the difficulties?

Please check if your child has received services from any of the following:

_____Occupational Therapy ______Physical Therapy ______Speech Therapy

If so, when, where (private or school), and for how long? Are these services ongoing?

Medical History:

Please indicate all that are applicable and ages(s):

_____ High fevers _____ Ear infections/tubes _____ Allergies

_____ Reflux _____ Seizures _____ Feeding difficulties

_____ Surgery / hospitalization (Please List)

Other significant accident, injury, or illness?

Please specify significant allergies, food restrictions, and/or special diets:

Physical or medical precautions or activity restrictions (i.e. due to heart problems, asthma, seizures, Physical limitations, etc.):

Please list any previous medical and/or diagnostic tests or evaluations (i.e. neurological, genetic testing, educational, speech/language, developmental, other) and their results.

Does child have a history of seizures? ____________ If yes, what is the protocol for seizure?

Social History:

What are your child's most preferred activities/ favorite toys?

Indoors: ____

Outdoors: ____

What are your child's least favorite activities?

Indoors: ____

Outdoors: ____

When is your child most calm or happy? ______________________________

When does your child become most frustrated? ___________________________

Does your child use a transitional object or security toy (bear, blanket, and pacifier)?

____

Does your child tend to have difficulty learning new motor tasks/games? ____________

____

Does your child resist participating in fine or gross motor tasks? Please explain: _______

____

Does your child have any recently acquired skills? ____________________________

____

Check the following items that best describe your child:

Visual

____ Wears glasses
____ has a diagnosed visual problem (describe):
____ Has difficulty finding / seeing things (shoes in the closet, toy in a toy basket)

Auditory and Language

____ Has a suspected or diagnosed hearing loss
____ Excessive talking interferes with listening
____ Nonverbal: Do they have a form of communication? List/circle the form of communication system (PECS, Sign Language, gestures used, etc.)

Oral-Motor and Respiratory Control

____ Displays poor lip control / lip closure for eating, drinking, using utensils
____ Has limited skills with blow toys, whistles, bubbles
____ Demonstrates poor saliva control (drools)
____ Chokes easily on liquids or solids. Specify: ___________________________
____ Coughs frequently during meals
____ Swallows food before completely chewed
____ Overstuffs mouth with food
____ Clenches jaw or grinds teeth

Self-Care Skills:

Check the tasks your child is able to complete *independently*

____ Take off (elastic waist) Pants
____ Take off t-shirt
____ Take off front opening shirt
____ Snaps / Unsnaps
____ Zippers (pull up/down)
____ Velcro on / off
____ Take off socks
____ Self-feeding (finger foods)
____ Uses fork
____ Uses open cup
____ Blows nose
____ Put on (elastic waist) pants
____ Put on t-shirt
____ Put on front opening shirt
____ Buttons
____ Zipper (engage/disengage)
____ Toileting
____ Put on socks
____ Uses spoon
____ Uses sippy cup
____ Uses a straw

Feeding:

Is your child a picky eater? ____
If so, please explain: ____
Preferred foods/textures/flavors: ____
Non-preferred foods/textures/flavors: _______________________________________
Appears to chew his/her food thoroughly: ____________________________________
If limited diet, what would you like your child to eat: _________________________
What does your child drink from: ____
List any other feeding concerns: ____

Sensory Processing:

Check the statements that relate to your child:
_____ My child often seems overwhelmed at public events/birthday parties
_____ My child is overly sensitive to touch
_____ My child responds negatively to loud, unexpected noises (e.g. sirens, vacuum)
_____ My child is a picky eater (textures, temperatures, colors)
_____ My child does not tolerate tags in their clothing
_____ My child is fidgety during meal time
_____ My child has difficulty tolerating changes in the routine
_____ My child is fearful of climbing, swinging, and movements activities
_____ My child seeks out excessive movement activities
_____ My child has difficulty paying attention in noisy places
_____ My child has difficulty attending birthday parties and going to restaurants
_____ My child jumps from one activity to another quickly
_____ My child is clumsy and falls often
_____ My child frequently throws temper tantrums
_____ My child has difficulty calming themselves down when upset
_____ My child becomes frustrated very easily
_____ My child has difficulty completing new motor tasks
_____ My child has difficulty putting puzzles together compared to same age peers
_____ My child has difficulty learning new motor tasks
_____ My child has difficulty regulating their emotional responses

Additional comments:

Please provide any other information that you would like to share about your child.

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HIPAA Release

I, ______________________________ as the parent/guardian of__________________________ intend for any agent named in this release to be treated with respect to their rights regarding the use of and disclosure of his/her individually identifiable health information and other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 42 U.S.C. 1320d and 45 C.F.R. 160-164.

I authorize the disclosure of any information governed by HIPAA to be provided to the following: (print full name and relationship)

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

Accordingly, I hereby authorize any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau, Inc., or other health-related clearinghouse that has provided treatment or services to the individual, or that has paid for or is seeking payment from me for such services, to give, disclose, and release any agent who is named herein and who is currently serving as such, without any past, present, or future medical or mental health condition, including all information relating to diagnosis and treatment of HIV/AIDS and mental illness.

This authority given to any named agent shall operate concurrently with any other agreement that I may have with the individual's health care provider to restrict access to disclosure of their identifiable health information. The individually identifiable health information and other medical records give disclosed, or released to any named agent may be subject to redisclosure by a named agent and may no longer be protected by HIPAA. The authority given to any named agent herein has no expiration date and shall expire only in the event that I revoke this HIPAA Release on the individual's behalf in writing and deliver it to their health care provider. There are no exceptions to my right to revoke this HIPPA Release.

Signature:_____________________________________ Date:______________________________

Consent for Treatment

I, ________________________________, the parent/legal guardian of ________________________________, hereby request and consent to Hope Center for Autism to perform treatment and care for my child as prescribed by a physician and/or recommended by an occupational therapist. I understand and am informed that, as in the practice of medicine, occupational therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about my child's condition, prior to treatment. I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with the treating therapist.

I consent and authorize Hope Center for Autism to administer treatment under the direction and supervision of a registered occupational therapist.

____________________________________ ____________________________

Signature of Parent/ Legal Guardian Date

Consent for Closed Circuit Television

I, ______________________________, as a client/visitor or parent/guardian of a client/visitor of the Hope Center for Autism give my consent for ________________________ to be recorded on a closed circuit television system. This system is video only. I understand that this system will be used to investigate any claims made against the staff, visitors, and/or clients of the Hope Center for Autism. I understand that this system will not be used in any restroom.

In the event that a claim has been made against a client/visitor or employee, the video will be reviewed by the Executive Director.

If required, the video will be turned in to proper legal authorities to view.

I hereby release the Hope Center for Autism, and any of its directors, officers, agents, employees, and clients from all claims of every kind on account of such use.

Client name:____

Legal guardian:____

Signature:____Date:______________

Authorization To Bill Health Insurance/Assignment of Benefits

I do hereby give full permission and authorize Hope Center for Autism to bill ___________________________ (Insurance Company) for services rendered by Hope Center to ____________________(Client). I agree to have any checks or payment made by said insurance company to be payable and deliverable to:

Hope Center for Autism
2751 Green Oaks Rd
Fort Worth, TX 76116

By signing this document I also agree to the following statements:

I understand that I am responsible for understanding information about my health insurance policy and providing such information to Hope Center for Autism for correct billing. I am also responsible for notifying Hope Center for Autism in the case of a change in my health insurance status- inclusive benefits and any information I receive relating to care I have or will receive in this office.

I understand that Hope Center for Autism will be providing services and will be billing my health insurance for those services at various times during the course of my care at this office. I understand that ultimately I am responsible for all payment relating to any and all charges related services that I have received at Hope Center for Autism during my care. I also understand that my insurance company and related policy plan may offer benefits for services provided at Hope Center for Autism, but that such benefits do not necessarily guarantee payment for those services.

I understand that the policy of Hope Center for Autism requires payment in full for all services rendered at the time of the visit, unless other financial arrangements have been made. If my account is not paid within 90 days of the date of service and no other financial arrangements have been made, I will be responsible for all legal fees, collection agency fees, and any other expenses incurred in collecting my account. I understand the above information and agree that my health history and related information was completed correctly and to the best of my knowledge and understand that it is my responsibility to alert Hope Center for Autism of any changes in my medical status or insurance coverage.

The undersigned agrees to observe and abide by all of the statements made above.

____ ____________________________

Signature Date

Cancellation Agreement

I agree to pay for the hours missed by absence if I fail to abide by the Hope Center Cancellation Policy.

You must notify the Hope Center for Autism 12 hours in advance of any cancellation.

You must give the Executive Director notice, two weeks prior to removing the individual from therapy. If you fail to do so you will be charged your weekly rate for the two weeks. This charge may not be billed to the insurance company and will be your responsibility to pay.

______________________________ Signature

____________________ Date

Permission to release client to someone other than parents/guardians

I give permission to release ______________________________ to the following person(s). ID is required.

Name	Relationship	Phone number

______________________________ ______________________________
Parent/Guardian Signature Date

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Illness Policy

Illness requires a client to be excluded from therapy to prevent the spread of infection to other clients and staff. Also, to allow the individual time to rest, recover, and be treated for their illness. This policy outlines illnesses and situations that require exclusion. If the individual appears to have any of the following (including, but not limited to), they should be kept home.

- Fever
- Diarrhea
- Vomiting
- Abdominal pain
- Conjunctivitis
- Impetigo
- Measles
- Mouth Sores

Client must be symptom/fever free for 24 hours before being allowed to return to therapy.

Conditions that do not require exclusion: common colds, runny nose (regardless of color or consistency of nasal discharge) and coughs.

_______________________________ _______________________

Signature Date

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