Blue Horizon Therapy

Pediatric Occupational Therapy and Speech Therapy

Initial Intake Form

Thank you for completing this form. We value your time and feel the completion of this form will assist us in better serving you and your child. The completed form will be reviewed with you by your therapist at your initial appointment and used for future reference.

Section I-General Information

Childs Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Address: (Street, City, State, Zip) _____

Home Phone: _____ Work Phone: (father) _____ (mother): _____

Cell Phone: (father) _____ (mother): _____

Father's Name: _____ Mother's Name: _____

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed (This is optional but useful.)

Email Address: _____

Language(s) Spoken in Home: _____

Emergency Contact: _____

Siblings (if any): _____

Pediatrician: _____ Phone # _____

Referred By: _____

Section II-Concerns

Describe your primary concern(s) regarding your child: _____

At what age did you first become concerned about your child: _____

Current medical diagnosis (if any): _____

What do you hope to obtain from this evaluation: _____

List your child's strengths and weaknesses: _____

Has you child ever received any of the following evaluations? ☐ Yes ☐ No If yes:

	When	Where	Outcome
Occupational Therapy			
Speech/Language			
Physical Therapy			
Hearing			
Vision			
Psychological			
Genetic			

Special accommodations at school _____

Section III-Developmental History

Length of pregnancy: ☐ Full Term ☐ Premature

Complications at birth: ☐ No ☐ Yes If yes describe: _____

Did your child have difficulty: ☐ Sucking ☐ Swallowing ☐ Chewing ☐ Changing to solid foods

Developmental Milestones (give approximate age)

Held Head Up		Held Bottle		Gestured	
Sat Alone		Finger Fed		Babbled	
Crawled		Used Utensils		Responded to Name	
Rolled Over		Drank From Cup		First Words	
Stood Alone		Dressed Self		Sentences	
Walked		Slept Through The Night		Followed Simple Directions	
Ran		Potty Trained			

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Developmental Milestones (continued)

Hand Preference	☐ Right	☐ Left	☐ Unsure	
Present Level of Activity	☐ Active	☐ Typical	☐ Low Arousal	

Current Communication Style (check all that apply):

☐ Crying	☐ Pointing	☐ Sign	☐ Loud Voice
☐ Eye Gaze	☐ Vocalization	☐ Words	☐ Monotone Voice
☐ Head Nodding	☐ Sentences	☐ Hoarse Voice	☐

Section IV-Health

Please mark any past and present medical concerns/conditions:

☐ Adenoidectomy	☐ CMV	☐ Frequent Diarrhea
☐ Allergies	☐ Communicable Disease (HIV, Herpes, TB)	☐ Headaches
☐ Asthma	☐ Concussion/Head Injury	☐ Hearing Aids
☐ Bronchitis	☐ Diabetes	☐ Hearing Problems
☐ Bed Wetting	☐ Drooling	☐ Heart Problems
☐ Blood Disease	☐ Ear Infections	☐ Jaundice
☐ Broken Bones	☐ Ear Tubes	☐ Kidney Problems
☐ Constipation	☐ Encephalitis	☐ Prescription Medication
☐ Corrective Lenses	☐ Feeding Problems	☐ Seizure

Has your child ever required hospitalization? ☐ No ☐ Yes If yes please describe: _____

Please list ANY/ALL medications your child is currently taking, including prescribed, over the counter, vitamins, etc. _____

Section V-Education Background

Name of School: _____ Grade: ____ Teacher: _____ School Phone # _____

Academic Ability: Above Grade Level ☐ At Grade Level ☐ Below Grade Level ☐ If below grade level, what areas: ____

Section VI-Health Insurance and Accountability Act

We will be calling to remind you of: Appointments/cancellations/rescheduling or verifying your personal health information

If you are not available, we will be leaving a detailed message at (please indicate): ___ **No – please do not leave any messages.**

Work Phone # _____ Home/Cell # _____ E-mail address _____

Section VII-Insurance Information

Insured's Name (Last, First, M.I.) _____ Patient Relationship to Insured _____

Insurance Plan Name or Program Name _____ Insurance Phone Number _____

Insured's I.D. Number _____ Insured's Group Number _____

Insured's Employer's Name _____ Insured's Date of Birth

Insured's Employer's Address _____

The above information is true to the best my knowledge. I authorize Blue Horizon Therapy or insurance company to release any information required to process my claims. I authorize my insurance benefits to be paid directly to Blue Horizon Therapy and understand that I am financially responsible for my balance.

Printed Name of Responsible Party _____ Date: _____

Signature of Responsible Party _____

(Please give your insurance card to the Coordinator)

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Treatment Policy

An evaluation is required prior to treatment. The fee for the evaluation is based on the time it takes for the therapist to evaluate and develop a written report and treatment plan. If you wish to bill your insurance company, a prescription from your pediatrician may be needed prior to setting up the evaluation appointment. Although a prescription is not required by law, most insurance companies require it before processing or paying out the claim.

Attendance Policy

I agree to give at least **24 hours** notice when canceling a set appointment. If I do not give this advance notice, I agree to pay fifty percent of the scheduled therapy or evaluation time. In the event of an emergency, I will notify Blue Horizon Therapy as soon as possible and make arrangements to reschedule the appointment.

I understand that if I arrive late for my scheduled appointment, Blue Horizon Therapy may not be able to accommodate the total treatment time, but I agree to pay for pre-scheduled therapy time in full. We realize that circumstances beyond your control do come up at times, and we would like to establish a solid relationship with your child.

Payment Policy

Payment for therapy services will be due **upon receipt** of service. If payment cannot be made within **five** business days, I agree to contact Blue Horizon Therapy so that arrangements can be made. Failure to do so within **ten** business days will result in the suspension of therapy services. A fee of $25.00 shall be charged for returned checks. I agree to pay any costs incurred in collecting any debt arising from my relationship with Blue Horizon Therapy.

Please make checks payable to Blue Horizon Therapy.

I have read, fully understand, and will comply with this agreement.

Parent/Guardian Printed Name _____ Child's Name _____ Date: _____

Parent/Guardian Signature _____