Fundamental Therapies

Today's Date:_______________

Patient Intake Sheet

PLEASE COMPLETE ALL INFORMATION

Patient Demographics

Patient Full Name:	Date of Birth:
Nickname, if applicable:	Age:
Address:	
Caregiver's Name:	Relationship to patient:
Daytime Phone:	Email Address:
Living with child? ☐Yes ☐No	
Caregiver's Name:	Relationship to patient:
Daytime Phone:	Email Address:
Living with child? ☐ Yes ☐ No	
Caregiver's Name:	Relationship to patient:
Daytime Phone:	Email Address:
Living with child? ☐ Yes ☐ No	
Emergency Contact:	Phone:
Emergency Contact:	Phone:

Siblings living in the home:		
Name:	Age:	Relationship to Patient:

Languages spoken in the home:	
Primary:	Spoken by:
Secondary:	Spoken by:

Medical Information

General health of your child: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Birth History

Was pregnancy full term? ☐Yes ☐ No Gestational weeks completed: _____________

Type of delivery (check all that apply):
☐ Vaginal ☐ Cesarian ☐ Breech. ☐ Forceps ☐ Suction

Length of hospital stay: _________________ Was the baby in distress at anytime? ☐Yes ☐ No

Birth Weight: ______ pounds _______ ounces

Please explain any complications the mother and/or baby had before, during or after the birth:

Were there any type of diagnoses or medical concerns about the baby after birth?

Has your child previously or is currently being treated for behavior services: ☐ Yes ☐ No

Present medications:

History of seizures: ☐Yes ☐ No	If yes, explain below.
Formal vision testing: ☐ Yes ☐No	If yes, results:
Formal hearing testing: ☐ Yes ☐No	If yes, results:
Have adaptive medical equipment: ☐Yes ☐No	If yes, explain below.
Follow a special diet: ☐ Yes ☐No	If yes, explain below.
Have allergies: ☐ Yes ☐ No	If yes, explain below.
Diagnosed with a medical diagnosis: ☐Yes ☐No	If yes, explain below.
Surgical history: ☐ Yes ☐ No	If yes, explain below.

Please explain any of the above medical information here:

Primary Physician Information (who is responsible for the primary healthcare of child):

Physician Name:	Practice Name:
Address:	Office Phone:

Secondary Physician (any other physician reports should be sent to):

Physician Name:	Practice Name:
Address:	Office Phone:

Who referred you to Fundamental Therapies? ____

Fundamental Therapies has permission to send a thank you letter to my referral source indicating my child has been seen for an evaluation and/or sending a report ☐Yes ☐ No

Billing Information

Person Responsible for Bills (who is responsible for all unpaid balances, copays and deductibles):	
Name:	Phone:
Address:	Soc Sec#:
Insurance Information (copy of all information from your card and give the card to the front desk for copy):	
Primary Insurance Name:	Policy ID #:
Address:	Group #:
	Phone #:
Cardholder's Name:	Birthday:
Relationship to Patient:	
Secondary Insurance Name:	Policy ID #:
Address:	Group #:
	Phone #:
Cardholder's Name:	Birthday:
Relationship to Patient:	

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Milestones / Developmental History

Age your child has completed the following:	
List age next to task:	**Any notes you want us to know:**
Roll over:	
Sit alone:	
Crawl / creep on all fours:	
Stand alone:	
Walk independently:	
Become toilet trained:	
Babble as an infant: ☐ Yes ☐ No	
Spoke first word:	
Put 2-3 words together:	
Speak clearly:	
Drink from a cup:	
Feed self with finger foods:	
Feed self with utensils:	
Dress self:	
Use crayons:	
Cut with scissors:	

Describe the following about your child:
Ability to communicate wants and needs:
Attention span:
Ability to follow directions:
How does your child handle stress? Describe their coping skills:
Ability to be redirected:
Strength and balance:
Hand dominance / preference:

Writing skills:
Visual skills:

Please check if your child has been diagnosed with any of the following:	
☐ ADD/ADHD	☐ Anxiety Disorder (specify):
☐ Autism Spectrum Disorder	☐ Cognitive Impairments
☐ Down Syndrome	☐ Dyslexia
☐ Emotional Disorder (specify:	☐ Fragile X Syndrome
☐ Learning Disability (specify):	☐ Mood Disorder (specify):
☐ Sensory Integration Dysfunction	☐ Sensory Processing Disorder
☐ Tourette's Syndrome	☐ Other: ______________________________

Educational History:
Has your child been evaluated by a school diagnostic team? ☐Yes ☐ No
If yes, please list results:
Is your child currently enrolled in a school program ☐Yes ☐ No
If yes, Name of School:
Highest grade completed:
Type of Classroom:
Please describe what subjects your child does well in:
Please describe what subjects your child demonstrates difficulty with:
Does your child receive special services? Describe:

Previous Testing / Intervention: Please list other professionals currently involved with your child's care
Name: Title: Phone:
Name: Title: Phone:
Name: Title: Phone:

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Concerns / Goals:

Describe any difficulties your child with the following:
Academic:
Activities of Daily Living (ADL):
Motor:
Play:
Relationships:
Sensory:
Speech/Language:
Other:

What are your biggest concerns at this time:
What goals do you want to achieve while at Fundamental Therapies:
Is there anything else you would like to discuss that hasn't been covered:

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Additional Information Sheet: Physical Therapy

Please fill this out if you are interested in your child receiving physical therapy at Fundamental Therapies and if you have concerns with any of the following areas: Please explain.

Amount of time your infant (0-12 months) spends in devices such as car seat, bouncy seat, swing, exersaucer:
Tummy time of developmental skills:
Posture:
Walking or running:
Balance or coordination:
Endurance or ability to keep up with peers:
Pain or orthopedic injury:
Adaptive equipment (orthotics, wheelchair, gait trainer):
Additional comments / concerns:

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Additional Information Sheet: Occupational Therapy

Please fill this out if you are interested in your child receiving occupational therapy at Fundamental Therapies and if you have concerns with any of the following areas: Please explain.

Sensitivity to messy play, textures, lights or sounds:
Over or under enjoying movements, such as swinging or spinning:
Using both hands for lifting, carrying or manipulating objects:
Clumsiness or tripping frequently:
Eye contact:
Social skills (such as body awareness, taking turns, and staying on topic):
Sustaining focus for play or school activities:
Reading comprehension, organization of tasks, or remembering details:
Discriminating shapes, colors, letters or numbers:
Copying shapes/colors/designs:
Dressing/undressing (buttons, zippers or snaps):
Using utensils, writing instruments, or scissors:
Transitioning between activities (i.e. needs to be prepared):
Please list any classroom skills your child's teacher has reported are concerns:
Additional comments / concerns:

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Additional Information Sheet: Speech and Language Therapy

Please fill this out if you are interested in your child receiving speech/language therapy at Fundamental Therapies and if you have concerns with any of the following areas: Please explain.

Articulation (i.e., difficulty saying specific sounds or hard to understand):
Please estimate in a percentage how much you are able to understand what your child says:
Ability to use language and words to communicate:
Eye contact:
Social skills: Describe how your child interacts with: Children: Adults:
Imitating sounds and/or actions:
Reading comprehension:
Written language (i.e. generating stories):
Answering questions: Describe how your child answers Yes/No Questions: "Wh" questions (what/where/when/who/why):
Comprehension: How does your child follow 1-step directions? How does your child follow 2-step directions?
The quality of sentences your child is able to form:
Does your child use any alternative modes of communication (i.e. sign/AAC devices, PECS)?:
Additional comments / concerns: