Easterseals Central Alabama
Eastersealscentralalabama.org | 334-288-0204

Occupational Therapy Intake Form

Today's Date:		How were you referred to me?	

INFORMATION ABOUT YOUR CHILD

Child's Full Name						Sex	☐ Male ☐ Female
Date of Birth		Age		School		Grade level	
Home Address					County		
Social Security Number					Race		
Primary Care Provider					Phone		
Current Medications and/or Allergies							
Diagnoses (i.e. autism, Down Syndrome, Speech delay, etc.)							

PARENT/GUARDIAN INFORMATION

Parent/Guardian Names (list all who will be involved in the child's therapy)

Name	Relationship	Phone	Email
		☐ H ☐ W ☐ C	
		☐ H ☐ W ☐ C	
		☐ H ☐ W ☐ C	
		☐ H ☐ W ☐ C	
☐ Check here if it's ok to call all parties listed above ☐ Check here if it's ok to leave messages for all parties listed above			
Is there anything I need to know about contacting the people listed?			

I have the legal right to give permission for therapy services, because my relationship to the child is:

☐ Birth Parent ☐ Adoptive Parent ☐ Legal guardian ☐ DHS caseworker

Emergency Contact

Name	Relationship	Phone

INSURANCE INFORMATION

Party Responsible for Payment		Date of Birth	
Address		Phone	
Occupation		Employer	
Employer Address		Phone	
Is Patient Covered by Insurance?	☐ Yes ☐ No	Co-Payment Amount	
Primary Insurance Company		Benefits Phone Number	
Sponsor's Name		Patient's Relationship to Sponsor	
SS#		Date of Birth	
Policy #		Group #	
Are you covered by more than one insurance co? If so, list			

The above information is true to the best of my knowledge. I consent to evaluation and treatment procedures for my child by……. I authorize the release of any medical or other information necessary to process claims. I also request payment of benefits to _____ for services provided and claimed. I understand I am financially responsible for any balance due.

☐ **I have received a copy of the privacy notice.**

_____ Patient/Guardian Signature

_____ Date

Your Reason for Contacting Us

Describe your reason for seeking occupational therapy for your child at this time.

What made the above a concern and how long has this reason influenced you/your life?

What have you tried to do to resolve these matters on your own? How are you currently taking care of this issue?

What are your thoughts about how I might be of help and/or what specific skills would you like to see your child achieve in Occupational Therapy?

If your child receives services from Easterseals Occupational Therapy clinic, would you like to receive appointment reminders via:

☐ Text message (mobile phone: _____)
☐ Email (email: _____)

Your Child's Care History

What is the child's birth history? ☐ adopted ☐ in vitro ☐ C-section ☐ vaginal

☐ Breastfed ☐ Bottle Fed

Please list any complications below (i.e.: If pregnancy was not full term, what was the gestational age? Was the child on oxygen or respiratory assistance? Did you experience complications with latching/feeding?)

Does your child have any medical conditions? (G-tube, seizures, diabetes, juvenile arthritis, etc.)

Any recent hospitalizations? Surgery? Injuries? (broken bone, tonsillectomy, concussion, etc.) Recent testing (MRI, swallow study, x-rays, hearing test, ADHD, IQ, genetic testing, etc.)?

List current medications (name, what for, dosage):

Allergies:

Sleeping Patterns (difficulties falling/staying asleep, hours at night, hours of nap, # of naps, etc.):

Developmental History

Please indicate the age each major milestone was reached

Sitting by Self	Crawling	Walking	First Word	Self-Feeding	Potty Training

Feeding/Self-care

Please describe any concerns regarding feeding or eating skills (i.e. using spoon/fork, drinking through a straw, ability to swallow, etc.)?

Do you have any concerns about your child's food choices (selective eater, will only tolerate certain food colors, textures, or temperatures)?

Do you have any concerns about your child's self-care or hygiene skills (managing buttons/snaps/zippers, toileting, tooth brushing, bathing, combing hair, etc)?

Play/Social

Please describe your child's personality below.

What are some of your child's favorite toys & interests?

What are your child's strengths?

Is there any type of play or toys that your child does not like, specifically?

How do you handle discipline at home?

Does your child have tantrums? ☐ Yes ☐ No

How often?

How does your child handle changes in variation in routine?

Does your child engage in eye contact during communication? ☐ Yes ☐ No

When given a choice, does your child prefer to play:

- ☐ Alone
- ☐ With 1-2 others
- ☐ Plays mostly with siblings
- ☐ Plays mostly with adults
- ☐ Has lots of friends

How does your child interact with others (i.e. shy, aggressive, cooperative, etc.)?

Does your child (check all that apply)….

- ☐ Answer questions logically
- ☐ Greet people arriving/leaving
- ☐ Engage in turn taking
- ☐ Initiate conversation
- ☐ Maintain a topic
- ☐ Recall & tell about everyday events
- ☐ Follow 1-step directions
- ☐ Follow multi-step directions

Sensory Motor

Please check all that apply:

- ☐ Frequently trips on own feet
- ☐ Walks on toes
- ☐ Frequently bumps into furniture, walls, other people
- ☐ Unaware of being touched or bumped unless done with force
- ☐ Unaware of that face/hands are dirty (food on face, running nose, etc.)
- ☐ Seems unsure how to move body; is clumsy or awkward
- ☐ Slumps or slouches when sitting; routinely places head in hands when at desk or table
- ☐ Has difficulty learning new motor tasks
- ☐ Is in constant motion
- ☐ Has difficulty sitting still
- ☐ Chews on pens, straws, shirts, etc.
- ☐ Frequently touches people & objects
- ☐ Frequently gets in others' space
- ☐ Is overly sensitive to touch, noise, smells, etc.
- ☐ Avoids touching certain textures (**please list in margin)**
- ☐ Avoids messy play (sand, paint, mud, play-doh, etc.)
- ☐ Only eats certain foods or textures (**please list in margin**)
- ☐ Is sensitive to clothing tags/textures
- ☐ Complains about having hair brushed
- ☐ Does not like to have finger nails trimmed
- ☐ Refuses to walk barefoot
- ☐ Has trouble falling or staying asleep
- ☐ Gets "stuck" on toy or task
- ☐ Is fearful on swings
- ☐ Is fearful on slide or other playground equipment
- ☐ Is fearless on playground equipment

ADDITIONAL INFORMATION

Please list other professionals your child has worked with in the past (counselors, ABA therapists, speech therapists, etc.)

Name/ Place Seen	Professional Designation	Currently Working With?	How Long?
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

School IEP? ☐ Yes ☐ No, Services Received: _____
504? ☐ Yes ☐ No, Accommodations Received: _____
Please bring a copy of IEP goals if currently receiving OT services at school

Additional services (developmental disability services, specialized camps/clinics, nanny, etc.)

Activities (sports, dance, art classes, etc.)

What have I not asked about that you would like me to know?

Thank you for taking the time to fill this out. I will review it with you during our first session.

Getting Familiar with Your Insurance Coverage

Here is a list of questions to ask your insurance carrier *before* your first appointment.

My primary insurance is:_____

Member services phone number:_____

Member #: _____ Policy#: _____ Group#: _____ Co-payment: $_____

Secondary insurance:_____

Member services phone number:_____

Member #: _____ Policy#: _____ Group#: _____ Co-payment: $_____

You may read the following questions to the insurance representative.

1. Does my insurance cover the occupational services that my child needs? Examples listed below.
    - OT evaluation CPT codes 97165, 97166, or 97167:
    - Treatment CPT code 97530:
2. If there is OT coverage, are there any exclusions?
3. Do I have a co-payment or is there a percentage of the bill for which I will be responsible?
4. Does my plan require a deductible be paid per calendar year before the coverage begins? What is the dollar amount?
5. Does my child have an out of pocket maximum that I pay per calendar year?
6. Does my insurance plan cover only a limited number of sessions for each calendar year?
7. Is there a requirement that I get a prior authorization and/or referral before I see a clinician / occupational therapist?
8. If yes, who do I contact?
    - Phone#:

Co-payments and deductibles are due at the time of service.

Please sign below and return this form along with a copy of your insurance card and your completed paperwork. Failure to complete and return this form may result in a delay in scheduling an appointment. Thank you for your cooperation.

I have verified the above information and understand that I am responsible for any charges that the insurance does not cover.

Child's Name: _____

_____ Patient/Guardian Signature

_____ Date