Allied Health Patient Intake Form

General Information

Patient Name:

Date of Birth:

Parent/Legal Guardian:

Phone (home):

Phone (work): Phone (cell):

Person Completing Form: Date:

Relationship to Patient:

Does your child have an IEP? ☐Yes ☐No

Emergency Contact 1: Phone:

Emergency Contact 2: Phone:

Who may bring your child to and/or pick up your child after therapy? Please list names and contact numbers.

Contact 1: Phone:

Contact 2: Phone:

Contact 3: Phone:

Diagnosis/Conditions/Reasons you are seeking rehabilitation services:

The primary goals for therapy are (Things you would like the patient to do in the home, school, or community that he or she can't do right now):

If the patient is a child, what are your child's favorite toys or play activities?

As a caregiver, how do you learn best?

☐ Reading
☐ Listening
☐ Demonstration
☐ Pictures

How does the patient learn best?

☐ Reading
☐ Listening
☐ Demonstration
☐ Pictures

As a caregiver, do you have any learning difficulties or barriers? ☐Yes ☐No

If yes, please specify:

Health History

Birth/Pregnancy History:

At what week in the pregnancy was the patient born?

Were there complications with the pregnancy? ☐ Yes ☐ No

If yes, please specify:

Were there any complications (problems) at birth? ☐ Yes ☐ No

If yes, please specify:

How would you rate the patient's general health? ☐ Good ☐ Fair ☐ Poor

If fair or poor, please explain:

Physicians: Please add additional names on a separate sheet of paper if you run out of space.

Primary Care Provider:

Doctor and Specialty:

Doctor and Specialty:

Doctor and Specialty:

Please list any restrictions the patient's doctor(s) have given:

Past/present conditions (Please specify with Y or N):

Heart Surgery	Y / N	Kidney Disease	Y / N	Cervical Spine Instability	Y / N
Diabetes	Y / N	Headaches/Migraines	Y / N	Feeding Tube	Y / N
Asthma	Y / N	High Blood Pressure	Y / N	Scoliosis	Y / N
Stroke	Y / N	Seizures	Y / N	Fractures	Y / N
Bleeding Disorder	Y / N	Sleep Problems	Y / N	Behavioral Concerns	Y / N
Cancer	Y / N	Shunt	Y / N	Depression	Y / N
Ear Infections	Y / N	Recurrent Pneumonia	Y / N	Anxiety	Y / N
Thyroid Disorder	Y / N	Upper Respiratory Infections	Y / N	Sensory Concerns	Y / N
Other:					

Allergies: Does the patient have any allergies (e.g., medications, latex, foods, environmental, etc.)?
☐Yes ☐No *If yes, please list:*

Allergy	Reaction

Medicines: Does the patient currently take any medicine(s)? ☐Yes ☐No
If yes, please list.

Medicine	Dose	Reason Taken	Medicine	Dose	Reason Taken

Surgeries/ Procedures: Has the patient had any surgeries/procedures? ☐Yes ☐No
If yes, please list below.

Surgery/Procedure	Year	Surgery/Procedure	Year

Please check the box for each test the patient has had:

☐Video Fluoroscopic Swallow Study ☐X-Ray ☐MRI ☐CT Scan ☐EMG ☐Neuropsychology

☐Other

Has the patient ever been on oxygen? ☐Yes ☐ No

If yes, for what reason?

Are there any other health problems you would like us to know about? ☐Yes ☐No

If yes, please specify:

Are the patient's vaccinations current? ☐Yes ☐No

If no, please specify:

Does the patient have any active infections (e.g., RSV, CMV, MRSA, VRE, C-DIFF, other)? ☐Yes ☐No

If yes, please specify:

Does the patient experience pain that is related to his or her condition? ☐Yes ☐No

If yes, please check the number that describes your child's level of pain.

(O for No Pain, 10 for Unbearable Pain)

☐0 ☐1 ☐2 ☐ 3 ☐4 ☐5 ☐6 ☐ 7 ☐8 ☐9 ☐10

How does the patient display pain?

How is the patient calmed or soothed when in pain?

Other History

Developmental Milestones:

Please list the approximate age the patient accomplished the following:

____ Lift head while on tummy	____ Started solid food
____ Rolled over	____ Held cup
____ Sat without support	____ Used fork
____ Crawled	____ Drank from sippy cup
____ Stood alone	____ Drank from open cup
____ Walked alone	____ Dry during day
____ Dress/undress self	____ Dry during night
____ Button/zip clothes	____ Gain bowel control

Hand Preference: ☐Left ☐Right

Does the patient have any bladder or bowel difficulties? ☐Yes ☐No

If yes, please describe:

Speech:

Please list the approximate age that the patient accomplished the following:

Developmental Task:	**Approximate Age:**	**Additional Responses:**
Babble (dada, baba, etc.)		
Said first words		
Combined words		
Responding when his/her name is called?		
Following simple directions?		

If patient is child:

Approximately how many words does your child use? ____

How does your child tell you what he/she wants?

Check any areas of concern regarding Speech and Language:

☐ Length of statements
☐ Ability to produce sounds correctly
☐ Ability to find the right word(s) (i.e. I want that, uh, that thing, uh, goes around)
☐ Fluency of speech (i.e. I-I-I will go to-to-to school now)
☐ Quality of voice (e.g. nasal, hoarse, pitch)
☐ Ability to stay on topic
☐ Ability to sustain attention
☐ Ability to establish peer relationships
☐ Ability to follow directions

When did you first notice difficulties with Speech and Language?

Does the patient become frustrated due to these difficulties?

Family history of Speech and Language difficulties? Y / N *If yes, please explain:*

Hearing/Vision:

Does the patient wear glasses? Y / N
Has the patient ever had a hearing test? Y / N *If yes, last date performed*
Results:
Does the patient wear a hearing aid? Y / N *If yes, please indicate*: Left☐ Right ☐
Has the patient ever had a vision test? Y / N *If yes, last date performed*
Results:

Feeding:
Does the patient have any feeding difficulty with the following?
Poor Suck ☐ Difficulty swallowing ☐ Difficulty chewing ☐ Gag/choke often ☐
Finger feeding ☐ Spoon use ☐ Required a feeding tube ☐ Reflux/vomiting ☐
List any other feeding concerns:
Is the patient a picky eater? Y / N Does the patient dislike particular textures of food? Y / N

Fine Motor/Upper Body:

Please indicate if the patient has problems with the following:

Strength? Y / N
Finger isolation? Y / N
In-hand Manipulation? Y / N
Thumb opposition (turn and rotate the thumb so it can touch each fingertip of the same hand)? Y / N
Pincer Grasp (grabbing small items using the thumb and index finger)? Y / N
Bilateral coordination (Using both side of the body at the same time)? Y / N
Reaching across the middle of the body? Y / N
Hand writing skills? Y / N
Scissor skills? Y / N
Self-help skills? Y / N

Sensory History:

Do the patient's hands, feet, and or tummy seem overly sensitive to touch? Y / N
Does the patient seem distractible or overactive? Y / N *If yes, please describe:*

Does the patient tolerate tooth brushing?	Y / N
Does the patient hesitate on uneven surfaces?	Y / N
Does the patient have difficulty positioning him/her self in a chair?	Y / N
Does the patient push/bump into other children/people?	Y / N
Does the patient seem generally weak?	Y / N
Does the patient have difficulty judging the height/depth of stairs?	Y / N
Does the patient walk/go down stairs heavily (stomping feet)?	Y / N
Does the patient have difficulty participating in sports with peers of the same age?	Y / N
Does the patient have a fear of using playground equipment (see-saw, swing)	Y / N
Does the patient have difficulty catching him/her self when falling?	Y / N
Does the patient not hear certain sounds?	Y / N
Does the patient respond negatively to certain sounds (running away, crying)?	Y / N
Does the patient seem to be a picky eater?	Y / N
Does the patient seem to always seek activities with pushing, pulling, jumping?	Y / N
Does the patient demand only to wear certain clothes all the time?	Y / N
Does the patient avoid getting hands messy?	Y / N
Does the patient get bothered by face washing, hair brushing?	Y / N
Does the patient spin, rock or hit self when distressed?	Y / N
Does the patient have difficulty keeping eyes on task/activity?	Y / N
Does the patient close one eye or tip head back when looking at something?	Y / N

Executive Function

Does the patient have difficulties with the following?

Create a plan to complete a task	Y / N
Organization (keep track of information and materials)	Y / N
Time management	Y / N
Working memory (remember relevant information while completing a complex task)	Y / N
Self-evaluate how he/she handles a situation	Y / N
Response inhibition (evaluate a situation prior to reacting)	Y / N
Emotional control	Y / N
Sustained attention	Y / N
Task initiation	Y / N
Flexibility	Y / N
Goal directed persistence	Y / N

Educational History:

What school does your child attend?

Current grade level:

How often does he/she attend school? days per week, hours per day

What are your child's strengths in school?

What areas at school are the most difficult for your child?

Any concerns you would like to share with us regarding your child (his/her sensory processing, home and/or school skills that are not age appropriate, etc.)?

What goal would you like your child to work on this year?

Please list any behavioral Issues.

Are there any Behavioral strategies being used?

Has your child ever had any previous Evaluations/ Therapy? ☐Yes ☐No

If yes, please provide dates, facility where performed, type of therapy and reason(s):

Date:	**Facility:**	**Type of Therapy:**	**Reason:**

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for the Mind and Motion Developmental Centers of GA.

In addition, I hereby consent to the use and disclosure of my child's personal health information for the purposes of treatment, Payment, and health care operations.

Initial: _____

Release of Information & Consent for Treatment

All information provided herein is true and correct.

I am aware of my child's diagnosis and wish him/her to receive treatment at Mind and Motion. I permit its employees and all other persons caring for my child to treat him/her in ways they judge are beneficial to him/her. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I understand that Mind and Motion also serves as a training and research facility and at times other therapists may be observing, handling, or have access to my child's medical information. I give my permission for Mind and Motion to use photographs and video taken of myself or my minor child during therapy sessions for educational, informational and promotional materials.

Initial: _____

Assignment of Benefits

I authorize release of payment directly to Mind and Motion for services billed for any therapeutic services provided.

This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Initial: _____

Payment Guarantee

I agree to pay Mind and Motion for the services provided to my child or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my child's treatments unless agreed to in writing by myself and a representative of Mind and Motion.

Parent/Guardian signature: _____

Date: _____ (mm/dd/yy)