SENSATIONAL KIDS, INC.

The Place For Pediatric Therapy

Developmental Intake Form

Date: _____

FAMILY AND MEDICAL HISTORY FORM

The information you provide will help our staff determine the care you need and the tests administered during your child's evaluation. A child's individual background, cultural experience, and family support are important factors in determining a treatment plan for your child.

Services Needed (Check all that apply):

☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy

Service Location (Check preferred location)

☐ Edmond- 14715 Bristol Park Blvd, Edmond OK 73013

☐ Sooner- 5701 SE 74th Street, Suite G, OKC OK 73135

General Information:

Child's Name: _____ (circle one) Male/Female Date of Birth: _____

Parent/Caregiver Names: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell: _____

Best # to call: (please circle one) Home / Business / Cell Email address: _____

Native Language(s) spoken in the home: _____ Primary language of child: _____

Emergency contact name and phone number: _____

Who referred you to Sensational Kids? _____

Who is your child's Pediatrician or Family Doctor? _____

Address: _____ Phone: _____ Fax: _____

Is your child in school? Yes or No If yes, where?_____

What grade? _____ Is child in any special classes or have special needs? _____

Does your child have an IEP? Yes or No If yes, we need a current copy returned with this form

Reason for visit:

Briefly state the reason your child needs an evaluation (include reasons for each evaluation if seeking more than one service)

_____

_____

When were the problems first identified? _____ By whom? _____

Is your child aware of the problem? If so, how does the child feel? _____

How does your child usually communicate (ex. gestures, single words, short phrases, sentences)?

_____

Family Information:

Parent/Caregiver: _____ Date of birth:_____

Occupation: _____ Highest Educational Level: _____

Relationship to child: (please circle): Biological Adoptive Step Foster Other

Parent/Caregiver: _____ Date of birth: _____
Occupation: _____ Highest Educational Level: _____
Relationship to child: (please circle): Biological Adoptive Step Foster Other

Please list siblings and/or anyone else that lives in the home:

NAME	AGE	RELATIONSHIP TO THE CHILD
1		
2		
3		
4		
5		

Does your child have a caregiver outside of the home? _____
If yes, when is child with this caregiver? _____

Is there anything about your religious beliefs we should know that may impact therapy or activities chosen for therapy? (ex. holiday worksheets, etc.)

_____

Is your child on a specific or special diet? (ex. gluten, casein, food coloring, sugar, etc.) _____

_____

What are your child's favorite activities, things to eat, and/or cartoons, which can be used as motivators during therapy? (ex. Pokémon, Thomas the Train, Dora, goldfish, pretzels, Skittles)

_____

_____

What activities does your child participate in regularly? (ex. soccer, church, gymnastics)

_____

What is your childs main form of mobility? (ex. crawl, walk, wheelchair/stroller)

_____

Child / Family Concerns and Goals:

Please describe what you want your child to achieve with the help of therapy. (What would you like your child to do that he/she can't do now?)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Medical History:

Were there any complications during pregnancy or delivery of your child? _____
If yes, please describe: _____

Gestational age at time of delivery (or # of weeks early or late): _____
What type of delivery (please circle one)? Vaginal Cesarean Section = elective or emergency
Birth Weight: _____ Length: _____
Was your child in the NICU? _____ If yes, how long? _____

Please make sure to include an explanation for any questions answered "yes."

ITEM	DESCRIPTION	YES	NO	EXPLANATION
1	Frequent Colds/Respiratory Illness			
2	Frequent Strep throat/sore throat			
3	Frequent Ear Infections (tubes placed?)			
4	Birth defect/genetic disorder			
5	Allergies or asthma			
6	Heart condition			
7	Visual disorder/vision problems			
8	Neurological disorder			
9	Seizures or convulsions			
10	Hearing Loss/Ear disorder			
11	Head injuries or concussions			
12	Any major childhood illness (pox, croup, measles, mumps, meningitis etc.)			
13	Hospitalization/surgery			

Does your child see any specialists (ex. neurology, psychiatrist, etc)

_____

Has your child had any difficulties with feeding? (ex. sucking, swallowing, drooling, chewing, reflux, choking)?
Yes___ No___ If yes, describe: _____

Does your child have difficulty keeping up with friends?
Yes___ No___ If yes, describe: _____

Does your child trip/fall often?
Yes___ No___ If yes, describe: _____

List current medications your child is taking, if any (please include any over the counter medications or medications given as needed): _____

_____

***Please note: If medications change at any time before evaluation or services begin, please provide written documentation to include in your child's records.**

Is your child ALLERGIC to any foods?
Yes ___ No ___ If yes, what? _____
Please list reactions to allergy along with severity: _____

Is your child ALLERGIC to any medications?
Yes ___ No ___ If yes, what? _____
Please list reactions to allergy along with severity: _____

Does your child use any special equipment for daily activities? Yes___ No___
(ex. glasses, hearing aide, splints, wheelchair, etc.)
If yes, please list: _____

Developmental History:
Please indicate the age when your child first performed each of the following INDEPENDENTLY. (It is okay to list an approximate age.) Please mark whether you believe your child accomplished the milestone Early, On Time, or Late. If your child has not yet achieved the milestone, write NA in the age column.

MILESTONE	EARLY	ON TIME	LATE	IF LATE, AT WHAT AGE?
Said first words / named single objects				
Used simple questions (ex., where's mom?)				
Followed simple 1 step directions				
Said 2-3 phrases				
Lifted head when on tummy				
Rolled Over				
Sat unsupported				
Crawled on hands and knees				
Stood Alone				
Walked by self				

Please check the tasks your child can do independently at this time:

Drink from: ___Bottle ___Spouted or special cup ___Straw ___Regular cup ___ Blows out candles
Feed Self: ___Finger feeds ___Eats with spoon ___Eats with fork ___Cuts with knife
Brush teeth: ___Tolerates parent ___Attempts to brush, but requires assistance ___Brushes independently
Undressing: ___Shirt ___Pants ___Underwear ___Socks ___Shoes
Dressing: ___Shirt ___Pants ___Underwear ___Socks ___Shoes
Shoelaces: ___Ties shoelaces ___Fastens Velcro shoes
Buttons: ___Opens large PJ buttons ___Opens small dress shirt buttons
___Fastens small dress shirt buttons ___Opens button on top of pants
Zippers: ___Pulls down to open ___Pulls up once pin is placed by adult ___Places pin and pulls up
Bladder: ___Trained days ___Trained nights ___Bowel trained
Sleeping: ___Sleeps all night ___Wakes up frequently
___Needs special routine (ex. music, light etc.) If yes, please explain routine:
_____
_____

Has your child had problems with any of the following (beyond expected for child's age)?

ITEM	DESCRIPTION	YES	NO	EXPLANATION
1	Drooling			
2	Thumb sucking			
3	Temper tantrums/Meltdowns			
4	Head banging			
5	Aggression/destructiveness			
6	Nervous habits (nail biting, etc.)			
7	Under or over reactive to sounds			
8	Under or over reactive to clothing or touch			
9	Under or over reactive to taste			
10	Under or over reactive to smell			
11	Any unusual fears?			
12	Socializing with neighborhood children			
13	Socializing with classmates			
14	Socializing with family			

***If you marked yes to questions 12, 13, or 14 please complete the next section "Social". If not, please continue on to "Family Stressors."**

Social:

Please place chek mark next to any social skill in which your child demonstrates difficulty:

____ Initiating/responding to greetings/farewells of peers
____ Sustaining activities with peers
____ Maintaining the "give and take" of conversations
____ Initiating conversations with peers
____ Responding to questions during conversation
____ Asking questions during conversation
____ Maintaining eye contact during conversation
____ Expressing verbally how she/he is feeling
____ Recognizing facial expressions, non-verbal cues, or "body language" of others

Family Stressors:(please note if any of the following stressful events happened in the last 12 months)

ITEM	DESCRIPTION	YES	No	EXPLANATION
1	Marital separations/divorce			
2	Death in the family			
3	Financial crisis			
4	Job change/difficulties			
5	School problems			
6	Legal problems			
7	Medical problems			
8	Household move			
9	Extended separation from parents			
10	Other stressful event			

*** Please complete speech and language portion ONLY IF you have concerns regarding your child's speech and/or language skills. Those seeking Occupational Therapy or Physical Therapy continue at ** below.**

Speech and Language:

Which of the following do you think your child understands?

____ His/Her own name ____ Family names ____ Names of objects
____ Names of body parts ____ Simple directions ____ Complex directions
____ Conversational speech

What methods does your child use for letting you know what he/she wants?

____ Looking at objects ____ Pointing at objects ____ Gestures
____ Crying ____ Vocalizing/grunting ____ Physical manipulation
____ Single words ____ 2-3 word combinations ____ Sentences

Which of the following best describes your child's speech?

____ Easy to understand ____ Difficult for parents to understand
____ Difficult for others to understand ____ Almost never understood by others
____ Different from other children of the same age

Which of the following best describes your child's reaction to his/her speech?

____ Is easily frustrated when not understood
____ Does not seem aware of speech/communication problem
____ Has been teased about his/her speech
____ Tries to say sounds or words more clearly when asked

Does your child have difficulty producing certain sounds? Yes or No If so, which sounds? _____
Does your child stutter when attempting to say a word? Yes or No
Do you have concerns about your child's voice? (too soft, too loud, etc.) Yes or No
What is the parent's reaction to child's speech? _____
_____
_____
When was the speech difficulty first noticed? _____
By whom? _____
Describe your child's current communication status (ex. nonverbal/verbal, sign language, gestures, PECS, etc.)
_____

****Has your child been evaluated or received therapy this calendar year, here or at any another facility?**
YES ____ NO ____ *If yes, and it has been in the last six months for the same therapy you are interested in receiving at our facility, please speak with the front office regarding transferring the evaluation.

If yes, please list below:

Previous evaluations/services:	*Who*	*Where*	*When*
Occupational Therapist			
Physical Therapist			
Speech Therapist			
Psychologist			
Other			

Focus and outcomes of above therapies: _____

_____

Billing Information for Accepted Insurance Carriers:

For Occupational Therapy, Physical Therapy and Speech Therapy, we are currently in-network providers for:

- Blue Cross/Blue Shield, Tricare, HealthChoice, OSMA and Medicaid/Soonercare, United Healthcare, Waterstone, and Cigna.

If you are a member of one of these providers, we will file the insurance claims for you. **Co-payment is due the day of service.** If services are not covered for any reason by your insurance company, you will be responsible for payment in full.

Billing Information for Out-of-Network Insurance Carriers:

If we are out-of-network with your insurance company, full payment of service is due the day of service. We will submit a claim on your behalf as a courtesy. Depending on your insurance plan, out-of-network benefits may be payable after your deductible is met. Some carriers will reimburse you directly, while others will reimburse the clinic. If the clinic is reimbursed the amount will be credited to your account and future payments for services will be adjusted accordingly. Written reports will be provided upon request of insurance company as needed.

Primary Insurance Information:

Insurance Co. Name:	_____	Phone#	_____
Group #	_____	ID #	_____
Name of Sponsor:	_____	Employer's Name:	_____
Sponsor SSN#	_____	Sponsor DOB:	_____

Secondary Insurance Information:

Insurance Co. Name:	_____	Phone#	_____
Group #	_____	ID #	_____
Name of Sponsor:	_____	Employer's Name:	_____
Sponsor SSN#	_____	Sponsor DOB:	_____

Billing Information for Private Pay Occupational Therapy and Speech Therapy:

If we are not in network with your insurance carrier or if the service(s) are a non-covered benefit from your insurance provider we do offer a "Same Day Discount Price". To qualify for this discounted price, the payment must be made the day of service. Initial Evaluation Fee is $350.00 if parents intend to receive follow up services if the child qualifies. Those needing an evaluation only, without intent to be served by Sensational Kids, will be charged an evaluation fee of $500. The initial evaluation fee includes an evaluation and a written report. If standardized testing is not required, a consultation fee of $175.00 will provide a one hour consultation and a written report/treatment goals. Occupational therapy treatment sessions are $120.00 for one hour session. Speech therapy treatment sessions are $60.00 per half hour or $120.00 for a full hour. Full hour sessions are at the discretion of parent and therapist, based on child's needs. If a child receives both speech (1 hour session) and occupational therapy (1 hour session) at this facility, an additional twenty-dollar discount will be given on each service ($100 for each service to equall $200 for one hour of speech and one hour of occupational therapy). Additional services provided include attending an IEP meeting ($125.00) and performing school observations or home observations for up to 1½ hours ($150.00). **All payments are due at the time of service(s) to qualify for these discounted prices.**

Financial Responsibility:

Individual who is financially responsible for this account:

Name: _____
DOB: _____
SSN: _____

- By signing this form I declare that I am the legal guardian of this minor and allowed by law to make decisions for testing this child. If my insurance or any other information changes prior to the evaluation or during the time my child receives therapy treatment it is my responsibility to provide written changes to Sensational Kids, Inc. (ex. new insurance information, home address, phone number, etc.).

- I understand I am financially responsible for services rendered by Sensational Kids, Inc.. and staff, and I understand that my insurance plan may pay a negotiated portion of these charges. I authorize my insurance company to pay benefits directly to Sensational Kids, Inc..

- I understand that in the event my insurance denies payment for services rendered, for my child, I agree to be personally responsible for those charges. I understand all co-pays designated by the insurance plan contract are my responsibility and are due at the time of my child's office visit. In the event my account is referred to a collection agency for payment, I will be responsible for any fees associated with collection of this debt. In the event my check is returned for insufficient funds, I will be charged a returned check fee of $25.00.

Signature: _____ Date: _____

Attendance Policy:

Since children and other family members understandably get sick, we will allow two cancellations per quarter (three month period). However, if a family needs to cancel additional sessions during this treatment period, payment of a $50.00 cancellation fee is required to keep the child's treatment time on the regular schedule. If attendance becomes an issue with an excessive amount of cancellations, then your child could be in jeopardy of being removed from our daily schedule.

Release of Information:

Sensational Kids' office may disclose any or all of the patient's information for insurance claim purposes. If another party is paying the patient's bill, Sensational Kids may then disclose any or all of the patient's information to that party to verify charges. Sensational Kid's office may disclose any or all of the patient's information to the patient's attending physician, consulting physician(s) and other health care providers who have a legitimate need for such information in the care and treatment of the patient.

Setting up Initial Evaluation:

As soon as completed paperwork is received at our office, the office manager will contact you to schedule an evaluation. If you have not received a call within one week of returning the paperwork, please contact our office. On the day of your child's evaluation, please have your child wear socks and shoes and corrective lenses if needed. We look forward to being part of your team!

By signing this form you agree to all the terms and conditions listed above.

Parent/Caregiver
(Please Print Name): _____ Signature: _____ Date: _____