NEW CLIENT INTAKE FORM

PERSONAL INFORMATION

Child's Name:___________________________________
DOB:_______________ Age:________________
Gender:_____________

Mother/Legal Guardian Name:________________________________ DOB:________________
Home Phone:______________________
Cell Phone:________________________
OK to leave message? Yes____ No____
Father/Legal Guardian Name:_________________________________ DOB:________________
Home Phone:______________________
Cell Phone:________________________
OK to leave message? Yes____ No____
Address where child lives:____
Child lives with:____
Current concerns bringing child to therapy:____

EMERGENCY CONTACT

Name:__________________________________
Relationship:_____________________________
Phone:__________________________________

INSURANCE INFORMATION

Primary Insurance:_________________________
Policy Number:_____________________________
Group Number:_____________________________
Phone Number:_____________________________
Insured's Name:____________________________
Insured's DOB:_____________________________

Secondary Insurance:_______________________ I DO NOT HAVE SECONDARY INSURANCE____
Policy Number:_____________________________
Group Number:_____________________________
Phone Number:_____________________________
Insured's Name:_____________________________
Insured's DOB:______________________________

EMERGENCY MEDICAL RELEASE

In the event medical attention is required for your child while on the premises/during treatment of Evergreen Pediatric Therapy, LLC, parent/guardian authorization is required. Please read and sign statement below:

As legal guardian of ____________________________, I give my permission for Evergreen Pediatric Therapy, LLC to contact emergency personnel in the event of a medical emergency.

Parent/Legal Guardian Name:____

Signature:_______________________________ Date:_____________________

HISTORY

Prenatal

Pregnancy illnesses/complications/medications:

____

____

Delivery: Vaginal____ C-section____

Born at how many weeks gestation:____

Complications/interventions at or after delivery:

____

Developmental History

Sitting:__________

Crawling:_________

Walking:__________

First word:_________

Feeding

Feeding problems as an infant? If yes, please describe:

____

Bottle or breastfed:_________________________

Difficulty transitioning to table foods? If yes, please describe:

____

Medical History

Please describe your child's illnesses, hospitalizations, surgeries if there have been any:

____

Allergies:_____________________________________

Medicine currently taking:__________________________________

Current or past therapy interventions: ____

Hearing tested?: Yes______ No_______ If yes, Pass_____ Fail______

Vision tested?: Yes________ No_______ If yes, glasses?_____

Education

Child attends:____

Grade:______________________

Does child have an IEP: Yes____ No____

Behavior

History of self-injury? If yes, please describe: ____

Difficulty with transitions: Yes____ No____

Engages appropriately with peers? If no, please describe:

____