PATIENT INTAKE AND CONSENT FORM

Date of Intake: _____

Child's Full Name: _____

Discipline Needed: ▢ Physical Therapy ▢ Occupational Therapy

DOB: _____ Male:▢ Female: ▢

Street Address: _____
City: _____ Zip Code: _____

Guardian Name: _____ Relationship to pt.: _____
Driver's license number: _____ State issued__:_____

Guardian Name: _____ Relationship to pt.: _____
Driver's license number: _____ State issued: _____

Primary phone: (____) ____-_____ ( )Cell ( )Home ( ) Work
Secondary phone: (____) ____-_____ ( ) Cell ( ) Home ( ) Work

May we TEXT you regarding appointments and scheduling matters (No confidential information will be shared via text unless written request made):
Primary number: ▢YES ▢NO
Secondary number: YES ▢NO

E-mail address: _____

Primary Language of Guardian: (s)_____

Primary Language of Patient: _____

Patient Availability (Times/days of the week) _____

In case of separated or divorced patient:
Who is the custodial parent?: _____

EMERGENCY CONTACT **other than parent** _:_____
Phone number: _____ Relationship: _____

INSURANCE INFORMATION:

Primary Insurance Carrier: _____ Pt. ID #: _____
Claims Phone: _____
Claims Address: _____

Secondary Insurance Carrier: _____ Pt. ID #: _____
Claims Phone: _____
Claims Address: _____

Guarantor/Insured's Information:
Name: _____
SS#: _____ DOB: _____
Relationship to patient: _____

PHYSICIAN INFORMATION:

Referring physician: _____

Contact person: _____

Practice Name: _____

Phone: _____ Fax: _____

Address: _____

City: _____ Zip Code: _____

TREATMENT INFORMATION:
o ICD-9: _____ Dx: _____

o 315.9 Developmental Delay o 742.1 Microcephaly

o 277.87 Mitochondrial Disease o 319 MR o 758.0 Down Syndrome

o 299.00 Autism o 765.20 Prematurity ▫ 781.3 Lack of Coordination ▫315.4 Developmental

Dyspraxia ▫348.3 Encephalopathy ▫ 299.90 PDD-NOS o 343.90 Cerebral Palsy

o 767.8 Torticollis o 787.20 Dysphagia o 348.30 Encephalopathy o 780.39 Seizures & NOS

o 359.1 Muscular Dystrophy o 781.20 Abnormality of Gait o 741.00 Spina Bifida

▫314.00 Attention Deficit Disorder without hyperactivity ▫ 314.01 Attention Deficit Disorder with

hyperactivity ▫783.3 Feeding difficulties and mismanagement ▫ 783.40 Lack of normal

physiological development, unspecified

What are your main concerns and goal for therapy?: _____

OTHER:
Is the residence a home or apartment complex? _____
Gate code, building number, etc.? _____
Pets? _____
Others that live in the home?
_____