

Spot On Therapy Group, LLC

Adult Intake Questionnaire

Name: _____ Age: _____ Date: _____

DOB: _____ Occupation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____

Email: _____

How you found out about us? _____

In case of emergency, contact: _____ Phone: _____

Primary Physician Name: _____ Physician's Phone: _____

Presenting Problem and Prior Treatment

What is your major concern that led you to seek help?

How long have you had these concerns? _____

Is there a particular reason you are seeking an appointment at this time? _____

Please check the areas of your life that are affected by these issues/concerns:

- _____ home _____ school _____ work
- _____ Church _____ public places (i.e., stores) please specify _____
- _____ other _____

What other concerns do you have?

Medical History

Are you currently being seen by other professionals? Please check any of the following whom you have contacted and/or from whom you have received services concerning your child and include any formal diagnoses given.

<u>Area of Service</u>	<u>Clinician</u>	<u>Date</u>	<u>Diagnosis/Recommendations</u>
<input type="checkbox"/> Occupational Therapists	_____	_____	_____
<input type="checkbox"/> Physical Therapist	_____	_____	_____
<input type="checkbox"/> Speech Language Pathologist	_____	_____	_____
<input type="checkbox"/> Vision Specialist	_____	_____	_____
<input type="checkbox"/> Hearing Specialist	_____	_____	_____
<input type="checkbox"/> Neurologist	_____	_____	_____
<input type="checkbox"/> Orthopedist	_____	_____	_____
<input type="checkbox"/> Psychologist	_____	_____	_____
<input type="checkbox"/> Counselor	_____	_____	_____
<input type="checkbox"/> Other:	_____	_____	_____

Are you allergic to any medications? No _____ Yes _____ If yes, list allergy and reaction

Are you allergic to anything other than medications? No _____ Yes _____ If yes, list allergy and reaction

1. List any medications you are currently taking in the columns below. (Use back of sheet if needed)

Medication(s)			
Dose			
Purpose			
Date Started			
Physician			
Side Effects			

What medical or physical problems do you have or have you had? Mark an X and then describe below.

	Past	Present	If yes, please explain
Cardiac Problems	___	___	_____
Allergies or food sensitivities	___	___	_____
Ear infections, frequent colds	___	___	_____
Poisoning or drug use or overdose	___	___	_____
Hospitalizations or surgeries	___	___	_____
Vision/hearing difficulties	___	___	_____

	Past	Present	If yes, please explain
Muscle or Verbal Tics	_____	_____	_____
Speech disorders	_____	_____	_____
Serious accidents/Injuries	_____	_____	_____
Any blows to the head or concussions	_____	_____	_____
Any loss of consciousness or seizures	_____	_____	_____
Very sensitive to feel of labels, seams, textures in clothes	_____	_____	_____
Bothered by loud or unexpected noises	_____	_____	_____
Very picky eater	_____	_____	_____
Shortness of breath	_____	_____	_____
Headaches	_____	_____	_____
Dizziness	_____	_____	_____
Motion Sickness	_____	_____	_____

Unusual Fears/Worries	_____	_____	_____
Depression	_____	_____	_____
Anxiety	_____	_____	_____
Compulsive Behaviors	_____	_____	_____
Smoke	_____	_____	_____
Drink	_____	_____	_____
Sleep Problems	_____	_____	_____

Please circle any of the following sleep problems you experience and then describe the severity or frequency in the space below:

- | | | |
|------------------------------|-------------------------|----------------|
| Delays going to bed | Not rested after sleep | Teeth grinding |
| Difficulty falling asleep | Nightmares (bad dreams) | Snoring |
| Difficulty waking in morning | Sleeping too much | Bedwetting |
| Physically restless sleep | Frequent waking | Sleep Apnea |

Other _____

Developmental History

	Yes	No	If yes, explain
Pregnancy problems	—	—	
<hr/>			
Difficulties during birth (apgar)	—	—	
1 st year of life problems (colicky, hard To soothe, etc), problems nursing	—	—	
Nursing, weaning, sleeping problems	—	—	
Motor development delays	—	—	
Speech & Language delays	—	—	
Toilet training delays	—	—	
Social Problems	—	—	

Family History

	Yes	No	
Attention or learning problems	—	—	
Depression, anxiety, mental illness	—	—	
Personal family substance abuse	—	—	
Physical, sexual, emotional abuse	—	—	
Marital problems, separations & divorce	—	—	
Trauma and significant stressors	—	—	

School/Work History

What is the furthest grade reached or highest degree attained in school? _____

What was the Grade Point Average in your last schooling? _____

Please mark with an "X" when any of the following has occurred.

	Elementary School	Middle School	High School	College	Work
Learning/academic problems	_____	_____	_____	_____	_____

Daydreaming	_____	_____	_____	_____	_____
Hyperactivity	_____	_____	_____	_____	_____
	Elementary School	Middle School	High School	College	Work
Impulsivity	_____	_____	_____	_____	_____
Reading difficulties	_____	_____	_____	_____	_____
Math difficulties	_____	_____	_____	_____	_____
Writing difficulties	_____	_____	_____	_____	_____
Poor grades	_____	_____	_____	_____	_____
Homework problems	_____	_____	_____	_____	_____
Behavior problems at school	_____	_____	_____	_____	_____
Anger	_____	_____	_____	_____	_____
Oppositional	_____	_____	_____	_____	_____
Destructive	_____	_____	_____	_____	_____
Peer problems	_____	_____	_____	_____	_____
Strongly disliked school	_____	_____	_____	_____	_____
Resource or other remedial assistance	_____	_____	_____	_____	_____
Special Education placement	_____	_____	_____	_____	_____
On Individualized Education Plan (IEP)	_____	_____	_____	_____	_____
Other (Please explain on back of page)	_____	_____	_____	_____	_____

Please circle any of the following that are current problems

- | | |
|--|---|
| Difficulty learning to read, blending sounds or reading smoothly | Difficulty spelling |
| Problems tracking while reading (losing place, missing words) | Poor handwriting (even if writing slowly) |
| Difficulty remembering what was read | Difficulty drawing or copying figures |
| Difficulty with math calculations | Poor sense of direction |
| Difficulty understanding math concepts | Poor balance or coordination, clumsy |
| Difficulty at written composition | |

OTHER

What other sources of personal strength do you call upon to face problems?(i.e., exercise, friends, music, faith, etc.)

Please describe your greatest strengths and any special abilities or talents.

How healthy is your diet? What problems, if any, have you had with sugar cravings, dieting or maintaining weight?

How much caffeine do you consume daily? _____(day)In what form?(coffee, soda, energy drink)_____

How does caffeine affect you? _____

Do you exercise? ___Yes ___No

If yes, what form of exercise and how often

Please list hobbies, special interests _____

Please include anything else you think might be helpful for us to know about you.

SPOT ON THERAPY GROUP, LLC

4840 Waller Road, Richmond VA 23230

(804) 893-5010 spotontherapygroup@gmail.com

RELEASE OF INFORMATION AGREEMENT

Client Name _____ Date of Birth _____

I request and authorize Spot On Therapy Group, LLC to release/exchange health care information of the client listed above to:

Name _____

Phone _____ Fax _____

Business/Affiliation with Client _____

Address _____

City/State _____ Zip _____

This authorization applies to the following information (please be specific)

This authorization expires on _____

Name _____

Phone _____ Fax _____

Business/Affiliation with Client _____

Address _____

City/State _____ Zip _____

This authorization applies to the following information (please be specific)

This authorization expires on _____

Name _____

Phone _____ Fax _____

Business/Affiliation with Client _____

Address _____

City/State _____ Zip _____

This authorization applies to the following information (please be specific)

This authorization expires on _____

.....

Print client or guardian's name

If child, name of child

Client or guardian's signature

Date

Spot On Therapy Group, LLC
Client Contact Information

Today's Date _____

Client Name: _____ DOB: _____
Social Security Number _____ Gender _____
Address: _____ City: _____
State _____ Zip _____ Email Address: _____
Home Phone: _____ Cell Phone: _____

Referred by:(name and title) _____
Primary Care Physician _____
Name of Practice _____
Address _____ Phone _____

If a child, parents please complete the following:

Mother's Name: _____ Occupation: _____
Address (if different from above) _____
Phone (if different from above): Home Phone _____ Cell _____
Work Phone: _____ Employer _____

Father's Name: _____ Occupation: _____
Address (if different from above) _____
Phone (if different from above): Home Phone _____ Cell _____
Work Phone: _____ Employer _____

In case of emergency contact:

Name _____ Phone _____
Relationship to client _____

Insurance/Payment Information

Person responsible for payment of services: _____
Insurance Company _____
Insured's Name _____ DOB _____
Insured's ID Number _____ Insured's Group Number _____
Client's relationship to insured _____
Insured's Social Security # _____

OFFICE USE ONLY

Insurance Deductible _____ Preauth required _____
Patient Copay or Coinsurance _____ Max Coverage per Year _____

Spot On Therapy Group, LLC.

4840 Waller Road

Richmond, VA 23230

spotontherapygroup@gmail.com (804)893-5010

Cancellation and No-Show Policy

Effective 7/15/2015

Please understand that we typically have a waiting list of clients and families who need our services. Ours is an appointment-based business, and we depend on clients honoring their reserved appointment times. A 24-hour notice is required for all cancellations. If a 24-hour notice is not given, then a \$50.00 fee will be charged for each occurrence. A \$50.00 fee will also be charged for failure to show up for a scheduled appointment. After three cancellations with less than 24-hour notice and/or no show appointments, then you will lose your regularly scheduled appointment time and will be placed on the week-to-week scheduling list (e.g. you will have to call each week to schedule your appointment) or you or your child may be discharged from therapy at that time. ** Exceptions (illness, death in family, etc.) are made on a case-by-case basis.

I have read and understand this cancellation notice and agree to the terms.

Spot On Therapy Group, LLC requires that we have a credit card on file for all clients. You will be notified prior to any charge greater than \$50.00. Initials _____ Date _____

It is our desire to work with you as a team, and we look forward to working with you and/or your child.

Sincerely,

The Staff
Spot On Therapy Group

Client Name

Client or Parent Signature

Appointment Day/Time _____ Date Reviewed with Patient: _____

Treating Therapist _____ Therapist Initials: _____

Therapist's Contact Info: email: _____ Phone: _____

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PRIVACY PRACTICES POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinicians or other treatment team members. *We may disclose PHI to any other consultant only with your specific written authorization.*

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support certain business activities including, but not limited to, sharing your PHI with third parties that perform various business activities (e.g., billing or typing services) only if we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. Your PHI may be disclosed via email, if you have given written permission, for appointment reminders, and to provide information about treatment alternatives or other health-related benefits and services.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose information to family members that are directly involved in you or your child's treatment *with your verbal permission.*

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI that we maintain about you. To exercise any of these rights, please submit your request in writing:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask for amendment of the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice. ****Please notify Spot On Therapy Group, LLC if you would like a copy. Please also check the appropriate box on the signature page, indicating you received a copy of this notice.**

Spot On Therapy Group, LLC Written Acknowledgement Form

By signing this form, I acknowledge and agree as follows:

I have been given the opportunity to read Spot On Therapy Group’s Notice of Privacy Practices policy statement prior to signing this acknowledgement form.

The Privacy Practices policy statement includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for Spot On Therapy Group, LLC to treat me and/or my child and to obtain payment for that treatment.

_____ By initialing, I indicate that I would like a printed copy of Spot On Therapy Group’s Notice of Privacy Practices Policy.

Name of Client

Date

Signature of Client or Parent/Guardian

Relationship to Client

Date Copy Provided to Client _____

Staff Initials _____