Tried-n-True Occupational Therapy Inc.
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Child Name:

Name (Last, First)	Date of Birth
Full Address	Primary Diagnosis

Responsible Party (Parent/Guardian):

Name (Last, First)	Date of Birth	Sex
Full Address	Relationship to patient	Email Address
Employer	Home Phone	Cell Phone

Referring Provider (**Child's Pediatrician/Referring Provider's Name**)

Name (Last, First)	Phone	Fax

Insurance Information

Name of Insurance	Policy Holder Name	Date of Birth
Policy Number	Group Number	Insurance Phone Number

Secondary Insurance Information (If applicable)

Name of Insurance	Policy Holder Name	Date of Birth
Policy Number	Group Number	Insurance Phone Number

Please ask your physician for a prescription for an Occupational Therapy, Physical Therapy and/or Speech/Language Therapy Evaluation, with a diagnosis, and fax to the **above number or give it to your child's teacher** if we service their school.

I, the parent/guardian authorize the Occupational Therapist and/or Speech/Language Pathologist to perform assessments, and provide recommendations, resources and training as deemed necessary for the client. I, the parent/guardian, authorize the Occupational Therapist and/or Speech/Language Pathologist to obtain information and/or records from relevant agencies and individuals, medical facilities, physician, and schools, release information and/or records to relevant agencies and individuals, discuss pertinent information with representatives of relevant agencies and individuals as such information relates to the client.

Signed: Name ____ Date ______________

Relationship to Child ____________________

Patient Contact Information

Today's Date:_______________

Child's Name:___________________________________ Date of Birth: ____________________________

Address:____ School & Grade:_____________________________

City:__________________________Zip Code:________ Teacher:_____________________________________

Parents' Names:_________________________________ Child lives with:______________________________

Mother's Home Phone:__________________________ Father's Home Phone:_________________________

Mother's Cell Phone:___________________________ Father's Cell Phone:_____________________________

Email Address:__________________________________ Email Address:__________________________________

Languages spoken in your home: ____

Referring Physician: ______________________________ Phone Number:________________________

What are your concerns and reasons for seeking a therapy evaluation?

____

____

Birth History

Were there any maternal illnesses or complications during pregnancy?

___yes ____no If yes, please explain:____

____

Birth Weight:___________ Were there complications during delivery? ____yes _____no

Full Term (Y/N)?:_______ How many Wks:_______ Caesarian delivery (Y/N)_________

Check any conditions that apply to child during the few weeks following birth:

____Anoxia (lack of oxygen) ____Jaundice ___Swallowing/Feeding difficulties ____Seizures

Any other medical condition of child following birth: ____

____

Health and Medical History

List significant medical history (i.e. surgeries, ear infections, etc):

____

____

List current diagnoses.____

____

Allergies:____

Current medications.____

____

Does your child have a history of frequent ear infections? _____yes _____no

If yes, has your child had tubes? _____yes ____No

Has your child had a hearing test? ____yes ____No Results?______________________________

Has your child had a vision exam? ____yes ____No Results?______________________________

Has (or does) your child participated in speech/language therapy, occupational therapy or physical therapy? If so, when & where were services provided. ____

____

____

Developmental Milestones

Please indicate whether the following milestones were achieved within the specified times:
____yes ____no sat up (6-8 months)
____yes ____no crawled/crept (7-10 months)
____yes ____no walked unaided (12 – 15 months)
____yes ____no babbling (9 – 12 months)
____yes ____no first words (12 – 15 months)
____yes ____no had 50 word vocabulary & combined 2 words (24 months)
____yes ____no fed himself/herself (2 ½ - 3 years)
____yes ____no achieved daytime bladder control (2 – 3 years)
____yes ____no achieved nighttime bladder control (2 ½ - 4 years)
____yes ____no cut with scissors (3 – 3 ½ years)

What is your child's primary method of communication? ( )Pointing ( )Gestures ( )Words
( ) Sentences ( )Other____

Does your child have difficulty with certain textures or temperatures of food? ____yes ____no
If so, explain:____
____

Is she/he a messy eater? ____yes ____no

Self-Care

Please check skills your child does regularly.

___drinks from open cup
___drinks from straw
___finger feeds
___ties shoes
___buttons & unbuttons pants
___eats with a fork
___takes off clothing
___ eats with a spoon
___brushes own teeth
___puts on clothing
___puts on socks & shoes
___removes socks & shoes
___buttons & unbuttons shirts

Sensory Processing and Behavior

Check characteristics your child currently displays. Make notes about behaviors that were significant in the past but have been overcome.

___appears unaware of objects
___appears unaware of people
___makes brief/limited eye contact
___displays uncooperative behavior
___has difficulty separating
___accepts limits
___described as friendly
___eats limited foods
___appears aware of objects
___appears aware of people
___makes consistent eye contact
___displays cooperative behavior
___separates easily
___tantrums frequently
___ covers ears (i.e. loud noises)
___playful
___described as calm
___has difficulty calming
___bangs head
___rocks
___sways
___flap hands
___ displays aggression
___follows directions

Notes:
____
____
____

Sleep Patterns: □regular □irregular □ sleeps through night
Activity Level: □appropriate □low □ high
Distressed by: □hair cutting □tooth-brushing □face washing

Please list any equipment you have in the home (i.e. assistive devices, braces, splints, communication equipment):

____

____

Social & Academic Development

How well does your child interact and get along with other children? ____________________________________

____

____

Describe concerns about your child's academic achievement? ____________________________________

____

____

Describe any concerns you have about your child's behavior: ____________________________________

____

____

List child's interests: ____

____

____

HIPAA COMPLIANT CONSENT FOR RELEASE OF INFORMATION

I hereby authorize Tried-n-True Occupational Therapy, Inc. and/or Maria Van Sant, LLC to release information from the records of (Child's Name)__________________________________. This information may to be released to the child's school, teachers, child's pediatrician and other professionals as needed for the purpose of developing an effective therapeutic program for the above named patient. The information to be released may include medical history, Occupational and/or Speech therapy evaluation and plan of treatment and on-going occupational and/or speech therapy progress notes

Notice

Tried-n-True Occupational Therapy, Inc., Maria Van Sant, LLC and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your child's health information confidential. If you have authorized the disclosure of your child's health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Your Rights

● I understand this authorization is voluntary.
● I may revoke this authorization at any time, provided that I do so in writing and submit it to Tried-n-True Occupational Therapy, Inc. and/or Maria Van Sant, LLC
● I am entitled to receive a copy of this authorization.

Expiration of Authorization

Unless otherwise revoked, this authorization expires when your child is dismissed from therapy services with Tried-n-True Occupational Therapy, Inc. and/or Maria Van Sant, LLC

Printed Name: ____

Signature____Date: _______________

ATTENDANCE POLICY

Consistent attendance is critical to the success of your child's progress. Please read and sign the following, indicating your understanding and agreement of the attendance policy:

1. If a client seen in-home, at their school, daycare or in the office is not able to receive their therapy session, the parent/caregiver is **required to call** the treating therapist **at least two hours before the appointment time to cancel the session**. Failure to meet this requirement will result in an unexcused absence.

2. **Unexcused absence**- If the client is not present at the time of the therapist's arrival to your child's home, school or daycare or is not present at the office within 10 minutes after their previously scheduled treatment time or you cancelled less than 2 hours before their scheduled session. This results in an unexcused absence.

3. After **three (3) unexcused absences**, the client's therapy services will be permanently discharged.

4. I acknowledge that Orlando Children's Therapy requests a commitment of at least 75% attendance for the month. I understand that if my child's attendance for the month drops below this, even for excused absences, that they may lose their scheduled time slot for therapy services.

These procedures have been implemented with the purpose of providing consistent and high quality services for your child. If you have any questions, please do not hesitate to contact your child's Therapist(s).

I have read the above attendance policy and agree to abide by the conditions stated.

____

Child's Name

______________________________________ _______________________________

Parent/Guardian Date: