118 E Broadway St, Thomas, OK 73669
kidstherapyconnection@gmail.com
P: 580-661-3517 F: 580-661-3528

Child Intake Form/History

Date of Intake: _____

Patient Name: _____

Date of Birth: _____/_____/_____

Address: _____ City: _____ Zip: _____

Guardian #1 Name: _____ Occupation: _____

Phone #: _____ Relationship to Child: _____

Guardian #2 Name: _____ Occupation: _____

Phone #: _____ Relationship to Child: _____

Guardian's Email: _____

Child's Grade: _____ School: _____

Has your child repeated a grade? _____

Does your child have an Individual Education Plan (IEP)? Yes No

If YES, please list any accommodations and/or services your child receives (aid, therapy services, Extended school year, testing accommodations, etc.)? _____

What is the primary language spoken? What languages are spoken in the home? _____

List all family members in the home (Name and Age): _____

_____

_____

Child's Allergies: _____

Child's Medications: _____

What are your primary concerns? _____

_____

_____

Prenatal & Birth History

Is child adopted? Yes No Is child in foster care? Yes No

Mother's general health during pregnancy (illness, accidents, medications, etc.): _____

_____

Did mother receive prenatal care? _____ Birth Weight: _____

Circle type of delivery: Vaginal Caesarian

At how many weeks was your child delivered: _____

Were there any immediate concerns after the birth? _____

_____

Were difficulties encountered during labor/delivery? _____

_____

Hearing

Newborn Hearing Screen (circle one): PASS FAIL

If the newborn hearing screening was failed, were follow up hearing screenings given? Yes No

Has your child received a recent hearing evaluation? When was it? What were the results? _____

_____

Does your child have a history of ear infections? Yes No

If YES, approximately how many ear infections have occurred in the past 6 months? _____

Does your child have Pressure Equalization (PE) Tubes? Yes No

If YES, please specify which ear(s) PE tubes were placed? Left Right Bilateral

When and where were the PE tubes placed? _____

Current Health

Has the child had any surgeries (e.g., tonsillectomy, adenoidectomy, etc,)? If yes, what type and when?

_____

_____

Describe any major accidents or hospitalizations:

_____

_____

_____

Developmental Milestones

Write the age these developmental milestones were achieved. If not yet achieved, write N/A.

	Sitting	Crawling	Walking	1 word	2 word sentences	Dress self	Toilet trained
Age							

Does your child have any motor difficulty (walking, running, using muscle coordination?) Yes No
If YES, please describe:

_____

_____

_____

Physical Therapy

Please indicate the amount of assistance your child needs to complete the following by placing a check in the corresponding box.

	Unable	<25% Independent	25% Independent	50% Independent	75% Independent	100% Independent
Jump on both feet						
Hop on one foot						
Skip						
Gallop						
Pump legs on Swing						
Climb stairs alternating legs						
Throw a ball						
Catch a ball						
Climb a play structure						
Ride a bike						
Take off pants						
Put on pants						
Take off shirt						
Put on shirt						
Take off shoes						
Put on shoes						

Do you have any concerns for Physical Therapy? _____

_____

_____

Occupational Therapy

Please indicate the amount of assistance your child needs to complete the following by placing a check in the corresponding box.

	Unable	<25% Independent	25% Independent	50% Independent	75% Independent	100% Independent
Pulls zipper pull						
Latches zipper						
Buttons						
Brushes Teeth						
Brushes Hair						
Bathing						
Self feeds with spoon						
Spears with fork						
Washes hands						
Toileting						
Indicates needing to go to bathroom						
Grasps crayon/pencil/marker						
Snips with scissors						
Cuts out shapes with scissors						
Writes his/her name						
String small beads						
Manages containers such as lunch boxes, baggies, & Tupperware						

Do you have any concerns for Occupational Therapy (avoiding textures, using utensils, writing, Self care, fine motor, visual, behaviors, etc.)? _____

_____

_____

Speech Therapy

Write the approximate age when your child began to do the following communication milestones:

	Age		Age
Babbled		Pointed to pictures	
Names simple objects		Followed simple 1-step commands	
Answered 'wh' questions		Engaged in conversation	

Does your child have difficulty articulating words? Yes No

If under 4 years of age, how many words does the child say

☐0-20 ☐21-50 ☐51-100 ☐101-150 ☐151-300 ☐301-500 ☐501+

Does the child produce sentences of the following length:

☐2 words ☐3 words ☐4 words ☐5+ words

What percentage of the child's speech do you understand? _____%

How well do people outside of the family understand their speech? _____%

If the child is not using words, how do they communicate? _____

_____

Social Skills

How does your child interact with other children? _____

_____

Do you have any behavioral concerns? _____

_____

Does your child have difficulty making & keeping friends? _____

Does your child have difficulty with taking turns? _____

Does your child attempt to control social situations? _____

Is your child unable to carry conversation with peers & adults? _____

What are some of your child's strengths? _____

_____

Child's favorite toys and activities: _____

_____

Child's dislikes/fears: _____

_____

Any other pertinent information you'd like to share? _____

_____

Feeding Therapy

Does your child choke or gag with certain foods/textures? _____

_____

During refusal, what is your child's typical behavior? _____

_____

What does meal time look like in your house? _____

_____

What foods has your child previously ate but does not anymore? _____

_____

What food does your child eat? _____

_____

Has your child been hospitalized for feeding related issues? _____

_____

Does your child have any of the following problems?

	Yes	Age	No
Food Refusal (refusing all or most foods)			
Food Selectivity by Texture (eating only certain textures)			
Food Selectivity by Type (eating a narrow variety of foods)			
Abnormal preferences (e.g., refuses food if not a certain temperature, eats only certain brands, must have specific utensils)			

What are your feeding concerns? _____

_____

Yes	Age	No		Yes	Age	No	
			Sippy cup				Regular Cup
			Bottle				Straw
			Feeds himself/herself				Spoon/utensils
			Finger foods				Non-oral

Infant Feeding

Describe your child's early/current feeding history: _____

Breastfed: How long? _____ Any issues? _____

Bottle fed: How long? _____ Any issues? _____

What formula was/is your baby on? _____

When did you introduce puréed foods? (Homemade or commercial) _____

How did your child do with transitioning to lumpy and solid food? _____

_____

Drinking Preferences Inventory

	Oz per day
Water	
Milk	
Tea	
Juice	
Pop	

Does your child drink a supplement? Yes No

If yes, which one? _____

How much/day _____

What kind of milk does your child usually drink? Whole 2% 1% Skim Soy Rice

Is your child's milk usually flavored? Y N If yes, what is it flavored with? _____

What issues are you trying to resolve? Check all that apply.

Increase the volume of food my child eats		Improve cup drinking	
Increase textures of foods my child eats		Improve mealtime behavior	
Increase weight gain		Decrease gagging during eating	
Increase the variety of foods		Decrease vomiting with eating	
Improve oral motor skills		Decrease tube feeding	

Was feeding interrupted at any time during the child's history? Yes No

If yes, how long? _____ If yes, provide the reason? _____

What types of foods are easiest for your child? _____

_____

What types of foods are hardest for your child? _____

_____

Does your child have taste preferences? If so, what are they? _____

_____

Does your child have preferred food textures? If so, what are they? _____

_____

Where does the child eat? (Lap, high chair, etc.)_____

Who usually feeds your child?_____

Who else can feed your child? _____

What works best when trying to feed your child?_____

_____

Which meal does your child do best with? _____

What are his/her usual meal and snack times? _____

How long does it take to feed your child? _____

Does the child have any of these behaviors/issues at mealtime? (Check all that apply)

Throws food during the meal		Messy eater	
Spits out the food		Takes food from others	
Cries or screams at meal		Refuses to self-feed	
Leaves the table before finished		Overeats	
Gets tired during eating		Tantrums during meals	

Does your child brush their teeth? Yes No

How many times in the last week did any of the following events occur?

	Always	Usually	Sometimes	Seldom	Never
Do you allow your child to eat whenever they request food between meals?					
Do you insist your child try ‘one bite’ of food?					
Do you physically put food into your child’s mouth?					
Do you allow your child to choose favorite plates or utensils to eat with?					
Do you punish your child for not eating (spanking or time-out)?					
Do you insist your child ‘clean his/her plate’ before they leave the table?					
Do you offer activities as a reward for eating?					
Do you give your child the option to eat other foods than those served?					
Do you send your child away from the table if he/she is not eating?					
Do you encourage your child to eat fruits or vegetables every day?					

	Age Started	Dose eat	Can eat	Never Tried	Cannot eat
Liquids/soups					
Stage 1/Stage 2 Baby food					
Stage 3/ Junior baby food					
Creamy foods					
Blenderized table food					
Mashed table food					
Chopped table food					
Regular table food					

FOOD INVENTORY

Name: _____ Date of Birth: _____

Completed By: _____ Date of Completion: _____

Directions: Fill out the following charts based on your child's daily eating patterns. Scores are based on always, sometimes and never. Please be sure to fill it out completely to ensure the best picture of your child's eating patterns. If you don't see a food listed, please write it in the "other" category.

KEY: N = Never S = Sometimes A = Always

Fruit

	N	S	A
Apple			
Strawberry			
Grapes			
Blueberry			
Raspberry			
Pineapple			
Oranges			
Blackberry			
Banana			
Melon:			
Other:			

Vegetables

	N	S	A
Carrot			
Cucumber			
Celery			
Broccoli			
Pepper			
Butternut Squash			
Sweet Potato			
Potato			
Peas			
Tomato:			
Other:			

Dairy

	N	S	A
Milk			
Butter			
Yogurt			
Keifer			
Cheese:			
Other:			
Other:			

Meat

	N	S	A
Steak			
Ground Hamburger			
Grilled Chicken			
Chicken Nuggets			
Turkey			
Fish			
Other:			

Carbohydrates

	N	S	A
Bread			
French Fries			
Pasta			
Cereal			
Sandwich			
Cookies			
Chips			
Other			
Other:			
Other:			
Other:			

Other

	N	S	A
Beans:			
Other:			
Other:			
Other:			
Other:			
Other:			
Other:			
Other:			
Other:			
Other:			
Other:			

Food Allergies? : __ Y __ N

If yes, what to: _____

Does your Child have a temperature preference for their food? : __ Y __ N

If yes, please describe: _____

_____

Prefer a specific brand of food or restaurant? : __ Y __ N

If yes, please list: _____

_____

Other information you would like us know : _____

_____

_____

_____

_____

Private Insurance Information

Patient Name: _____

Patient Date of Birth: _____

Insurance Company: _____

ID: _____ **Group #:** _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Relationship to Patient: _____

ATTENDANCE & CANCELLATION POLICY

EXPECTATIONS:

- Please be consistent and on time. If you arrive late for a scheduled appointment, your child's session will be cut short and will end at the regularly scheduled time.
- Ensure child has a clean diaper or has gone to the bathroom prior to therapy beginning.
- Your child's progress and success requires a major commitment from you that goes beyond the time a child spends directly with the therapist.
- Our expectations for follow through with homework and home programs are high.
- Each child has a therapy time slot that is kept only for him/her. We make every attempt to schedule appointments on the same day and time each week. It is critical that you arrange an appointment time that you can be sure to accommodate.
- Therapy appointments, particularly after school, are in high demand and require everyone's effort to assure efficiency and continuity of services for all children.
- If you are running behind, please call and notify us with an estimated time of arrival.

CANCELLATION:

- A 70% attendance rate is essential.
- If you cancel via our text reminder, please reply with a reason as to why you are missing as it helps us document for insurance authorization and payment approvals. You can also call and leave a voicemail as it is available 24/7.
- We reserve the right to reduce to 1x week or drop to a week by week basis if attendance is less than 70%.
- Therapy will be terminated following 2 no-shows in a 3 month period.
- Make-ups may be workable with a different therapist. When appropriate, seeing a different OT, PT, or ST is a wonderful opportunity to gain fresh ideas and to assist your child with tolerating changes/encouraging flexibility.

ILLNESS:

- **Please do not bring your child if they are sick.** We require that your child is fever free (without medication) and/or has not vomited for 24 hours prior to returning for therapy.
- Excused cancellations: fever, vomiting, diarrhea, hospitalization, specialist appointment, family death, pink eye, hand foot mouth, chicken pox, unexplained rash, severe respiratory illness, staph/MRSA, lice, bedbugs or other infestation, etc. We may require a written physician confirmation that your child is cleared to return for therapy.
- Unexcused cancellations that we highly suggest an effort to reschedule: allergies, cough, transportation, school events, vacation, dentist or PCP appointments.
- If your child arrives for therapy and is visibly ill and potentially contagious, **we reserve the right to refuse treatment** in order to protect the wellness of other children and our staff.
- We are aware that illness does not always afford us 24 hours notice! If your child **comes home from school sick** on the day of your scheduled appointment, please call the office **IMMEDIATELY**.

For inclement weather please check our social media or call the office (we will change the voicemail). If nothing is noted then sessions are occurring as scheduled.

In some cases, a family may need to re-assess their individual circumstances, family dynamics, lifestyle and current priorities. Perhaps therapy may be more beneficial for your child at a future time when it can be made a priority.

I have read the above policy and agree to abide by it.

_____ _____

Client Name Date

_____ _____

Signature of Guardian Relationship to Client

118 E Broadway Thomas, OK 73669
kidstherapyconnection@gmail.com
P: 580-661-3517 F: 580-661-3528

Consent and Release of Photographs / Videos

☐ I, _____ (client or parent/guardian name) give consent to Kids Therapy Connection, PLLC or any party authorized by Kids Therapy Connection, PLLC to photograph and/or video record _____ (client name) in connection with his/her therapy sessions, for any purpose subject to the therapist's discretion including but not limited to educational publication, for teaching purposes, and demonstration of progression of his/her skills.

☐ I authorize Kids Therapy Connection, PLLC to use pictures of _____ (client name) for promotional purposes (ex. brochures, website, etc.)

☐ I acknowledge that I will receive no financial compensation for providing consent since my participation with Kids Therapy Connection, PLLC in providing my consent and release is voluntary.

☐ I hereby release Kids Therapy Connection, PLLC, their contractors, their employees and/or any third parties involved in the creation or publication of Kids Therapy Connection, PLLC. Publication from any and all liability that may arise in connection with the expressed and implied use of all photographs and videos outlined in this form.

☐ I reserve the right to revoke this agreement at any time. I understand that my right to revoke must be done in writing.

I am the client, parent or legal guardian of the person named below and have the legal authority to execute this consent and release.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

Parental Consent Form

*** Form must be completed in its entirety or will not be accepted**

Member Name: _____
Member RID #: _____
Member Diagnosis: _____

I (print name of parent/legal guardian)_____
hereby authorize (print name of provider) _____
to evaluate, as well as provide any subsequent treatment based on the evaluation results for (please check all services that apply) _____ Physical Therapy, _____ Occupational Therapy and/or _____Speech Therapy for child named above.

_____
Signature of Parent/Legal Guardian if a minor

_____
Date Signed by Parent/Legal Guardian

_____
Relationship to Member

_____
Signature of Therapist or Representative of Therapy Group

_____
Date Signed by Provider