Alyssa Frey, M.S., OTR/L, LLC
11 Broadview Ave. Maplewood, NJ 07040
alyssafreycst@gmail.com

INFANT INTAKE FORM

1. General Information

Child's name ____

Parent's name ____

Phone ____

Address ____

Email ____

Pediatrician ____

Referred by ____

Medical issues/procedures ____

Current medications ____

2. Prenatal Health of Mother

Medical issues ____

____

Genetic testing ____

Medications ____

Stress ____

Exercise ____

Difficulty conceiving ____

Family history of allergies ____

3. Birth

Type of delivery ____

Interventions (forceps, vacuum, epidural, caesarean) ______________________________

Duration of delivery ____

Location of delivery (hospital, home, birthing center)______________________________

Support staff (midwife, doula) ____

Other ____

Alyssa Frey, M.S., OTR/L, LLC
11 Broadview Ave. Maplewood, NJ 07040
alyssafreycst@gmail.com

4. **Feeding**

Breastfeeding/bottle ____

Quality of latch and suck ____

Is feeding easier one side than the other? ____

Birth weight ____________________________________

Current weight __________________________________

Other (feeding pattern) ____

5. **Digestive**

Colic (Yes/No): _____________

Reflux (Yes/No): _____________

Arching pattern (Yes/No): _____________

Flatulence (Yes/No): _____________

Bowel habits: ____

6. **Sleep patterns**

Family bed, crib and patterns ____

____

7. **Current therapies child is receiving:**

____

____

____

8. **Main goals of therapy**

____

____

____

____

Parent/Guardian signature *(sign by entering first and last name)*

Alyssa Frey, M.S., OTR/L, LLC
11 Broadview Ave. Maplewood, NJ 07040
alyssafreycst@gmail.com

DISCLOSURES TO INDIVIDUALS AND HIPAA PRIVACY AUTHORIZATION FORM

There may be times when it is necessary for an individual involved in your care to call me to inquire about your personal health information or billing information. Please take a few moments to complete this section.

I authorize Alyssa Frey, M.S., OTR/L, LLC to use and disclose health information related to my current treatment to: *Please indicate name, relationship, and other relevant information.*

1.____

2. ____

3. ____

4. ____

5. ____

This authorization for release of information covers all past, present, and future periods.

☐ **I authorize the release of my complete health record.**

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature: ________________________________

Indicate relationship to client (e.g., parent, guardian) _________________________________

Date: _________________