

**CHILD INTAKE FORM (Ages 2-12 years old)**

**General Information**

Child's Name: \_\_\_\_\_

Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parents' Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

Pediatrician: \_\_\_\_\_

Referred By: \_\_\_\_\_

**Prenatal History**

History of Pregnancy (medical issues/medications):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Labor and Delivery**

Length of pregnancy: \_\_\_\_\_ Type of Delivery: \_\_\_\_\_

Complications/Interventions: \_\_\_\_\_

\_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

**Early History Condition of Newborn**

Problems/Concerns: \_\_\_\_\_

Feeding: (breast/bottle/combo/special formula/etc.): \_\_\_\_\_

Colic (yes/no): \_\_\_\_\_

Reflux (yes/no): \_\_\_\_\_

Arching Pattern (yes/no): \_\_\_\_\_

Flatulence (yes/no): \_\_\_\_\_

Bowel Issues (yes/no): \_\_\_\_\_

Difficulty Sleeping/Settling (yes/no): \_\_\_\_\_

**Developmental Milestones (indicate age)**

Sat Alone: \_\_\_\_\_ Crawled: \_\_\_\_\_ Walked: \_\_\_\_\_ Ran: \_\_\_\_\_

**General Health**

Surgery/hospitalizations: \_\_\_\_\_

Past injuries: \_\_\_\_\_

Recent or current medication: \_\_\_\_\_

Allergies/sensitivities: \_\_\_\_\_

Eating (picky/appetite): \_\_\_\_\_

Eye problems: \_\_\_\_\_

Ear Infections/hearing difficulties: \_\_\_\_\_

Activity level (low, medium, high): \_\_\_\_\_

**Current therapies/services:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Main goals of therapy:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Parent signature** *Enter first and last name:* \_\_\_\_\_

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**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: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to client (e.g self, parent, guardian, etc) \_\_\_\_\_