Journeys
Occupational Therapy

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PEDIATRIC INFORMATION FORM

Name________________________________Age:________DOB:_____________Today's Date__________

Parent/Guardian Name: ____

Address_______________________________________City/State______________________Zip_________

Phone (H):_______________________(W)________________________(C)__________________________

Email:_______________________________________Occupation____________________________________

Other Parent/Guardian Name: ____

Contact info if different than above:

Address_______________________________________City/State_______________________Zip_________

Phone (H):_______________________(W)_________________________(C)_________________________

Email:_______________________________________Occupation____________________________________

Emergency Contact:____Phone:________________________

Who referred you to us?_______________________________May we thank them? Yes Please don't.

Has your child received Occupational Therapy before? ______ If so, where, for what issue, and for how long?____

Primary reason for appointment?____

Does your child have a medical diagnosis?____

Name of school child attends (if applicable)____Grade:______

Is there any recent crisis or stress going on that is important to your child's development?

____

Please list your child's strengths:____

____

Please list areas of concern (your goals for treatment):____

____

Is your child receiving any other intervention/treatment? Yes No

If so, what? ____

Age(s) and sex(es) of siblings:____

Background Information

Prenatal & Birth History(if known): (Please circle and describe)

Complications, illness/infections/stress during pregnancy? Y / N________________________________

Complications during labor and delivery? Y / N ________________________________

Forceps/ vacuum/ C-section? Y / N (elaborate)________________________________

Birth order ______ Birth Weight________________

Premature / Full Term / Postmature How many weeks gestation at delivery: ________

Breast Fed? Y / N How Long?______ Strong Suck? Y / N Spit up frequently? Y / N

Any feeding challenges?________________________________

History of tethered oral tissues / torticollis / brachiocephaly / plagiocephaly?____________________

Problems with Respiration / Sleeping? ________________________________

Irritable / Happy / Quiet Baby?________________________________

Does/did baby arch back & head when upset? Y / N________________________________

Does/did baby enjoy tummy time play? Y / N ________________________________

Developmental Milestones: Please note approximate age at which your child did the following:

Sat________Belly Crawled_________Crawled on hands/knees_________Cruised_________Walked________

Said first words_________Talked________Toilet trained (bladder)________(bowels)________(night)_____

Undressed self_________Dressed self_________Managed snaps, zippers, buttons__________

Tied shoes_______Preferred hand L / R____Age established? _______No hand preference_________

Medical History: (please add pertinent details)

Ear Infections? Y / N (how many, at what ages?)________________________________

Allergies? Y / N ________________________________

Seizures? Y / N ________________________________

Injuries? Y / N ________________________________

Hospitalizations? Y / N________________________________

Glasses? Y / N (what for?)________________________________

Has your child had corrective surgery for strabismus or eye motor difficulties? Yes No

Medications? Y / N (please list, including OTC)________________________________

Any other pertinent medical information, including precautions or allergies the therapist should be aware of, especially contraindications to active movement, or hydrocephaly?______________________

____

Primary Physician: ________________________________Practice Name: ________________________

Any other relevant physicians or practitioners:________________________________

CONSENT FOR CARE

You have the right to seek a second opinion or to end the evaluation/treatment at any time. You are entitled to information about the methods and techniques used in the evaluation/treatment. You may also ask the therapist for information about their training and credentials.

I, ___________________________, understand that Occupational Therapy and/or Craniosacral Therapy is not a substitute for standard medical care. I will alert the practitioner to any changes in my child's health status, including medication changes. It is my choice to receive Occupational Therapy and/or Craniosacral Therapy for my child with an understanding of the risks and benefits, and I give my consent for treatment of my minor child. I understand that there is no stated guarantee for effectiveness of treatment.

Signature________________________________Date___________

PAYMENT POLICY

Full payment is due at the time of service, unless other arrangements have been made in advance. Comprehensive evaluation rate is $350, and includes standardized or nonstandardized testing as appropriate, observations, interviews/phone conversations, and written report. On prior agreement for private pay only services (not submitting to insurance) a brief eval without a report can be completed for $150. Treatment rate is $100 for a 50 minute session. Late arrivals cannot be guaranteed an extension of scheduled treatment time, and will be responsible for full fee. We are not in network with any insurance companies; we can submit as an out of network provider on your behalf if receiving medically-based Occupational Therapy services with an MD script for OT services. Itemized invoices can be provided at the end of the month for your health card account.

Cancellations: Please make any cancellations or schedule changes 24-48 hours in advance when at all possible (exceptions for illness and weather-related events); cancellations within 24 hours or no-shows will be subject to a $50 cancellation fee at therapists' discretion.

Please initial indicating understanding of payment & cancellation policies:_______________