Honeybee Pediatric Therapy, LLC

Melissa Wood, OTR/L

INTAKE FORM **Intake Date:** _____

CHILD'S NAME	
DATE OF BIRTH	
DIAGNOSIS	
ALLERGIES	
MEDICATIONS	
PARENT/GUARDIAN #1	
ADDRESS	
PHONE (HOME, WORK, CELL)	
EMAIL	
PARENT/GUARDIAN #2	
ADDRESS	
PHONE (HOME, WORK, CELL)	
EMAIL	
Physician	
Address	
Telephone #	
CDS Site	
Service Coordinator	
Phone #	
Child Care/Preschool/School	
Phone	
Community Based Case Manager	
Phone #	

28 Winter Street, Norway Maine 04268 (207) 739-2021

Name:_____DOB:_____

Please initial yes or no for each permission requested.		
YES	NO	
MEDICAL		
		PERMISSION FOR EMERGENCY MEDICAL TREATMENT I give permission for my child to receive emergency medical treatment for incidents that occur at the Honeybee Pediatric Therapy Clinic or contracted site. HPT has my permission to administer First Aid and/or CPR, to seek further emergency medical care, and to have access to my child's health information. I agree that transportation may be provided by ambulance if hospital treatment is deemed necessary. I understand that I will be responsible for paying for any services rendered by ambulance/hospital/medical providers. My preference of hospital is:_____.
		POSTING OF MEDICAL INFORMATION Honeybee Pediatric Therapy has my permission to post my child's allergies and/or medical plan in therapy rooms.
MEDIA PERMISSION		
		I give permission for my child to be photographed
		I give permission for my child to be videoed.
		I give permission for my child to be photographed, videoed and/or interviewed for internal HPT educational/program use.
		I give permission for photographs, or videos of my child to be posted to HPT Facebook site or website, or articles/stories in the news media.
RELEASE FOR APPOINTMENT REMINDERS		
		I authorize HPT to send appt and other reminders by text at:
		I authorize HPT to send reminders, paperwork and updates by emails at:
COMMUNITY PERMISSION		
		I give permission for my child to go on occasional neighborhood walks within close proximity of the clinic with Honeybee Pediatric Therapy Staff as part of treatment activity or to/from another program
COURT ORDER		
		Are there any court orders of which we should be aware (custody orders, protection orders, etc)? *Please attach copies of court orders.*
INFORMED CONSENT FOR OCCUPATIONAL THERAPY		
		As the parent/guardian, I hereby request and consent to Honeybee Pediatric Therapy, LLC to perform treatment and care for my child as prescribed by a physician and/or recommended by an occupational therapist. I understand and am informed that, as in the practice of medicine, occupational therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about my child's condition, prior to treatment. I have carefully read and fully understand this Informed Consent Form.
FINANCIAL		
		I authorize billing of health insurance for therapy services.
		Is this a referral based on an IEP/IFSP through CDS?
		I am aware there will be no personal cost to me for my child to receive services for which he/she is eligible according to the IFSP/IEP completed with CDS, if they made a formal referral to Honeybee. If these services are not part of an IFSP/IEP, or are above and beyond what CDS has recommended, I will be responsible for any charges not covered by my health insurance.
		I authorize billing of CDS for Therapy Services.
		I understand I am responsible for any balance left by my insurance for my deductible, co-pays, and co-insurances.
Note: These authorizations will remain valid until changes are requested and submitted in writing by the parent/guardian of this child		

Parent/Guardian Signature:_____ Date:_____

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Name:_____DOB:_____

INSURANCE INFORMATION	
PRIMARY	
COMPANY	
SUBSCRIBER'S NAME	
RELATIONSHIP TO CHILD	
SUBSCRIBER'S BIRTHDATE	
SUBSCRIBER'S SOCIAL SECURITY	
SUBSCRIBER'S EMPLOYER	
CERTIFICATE #	
GROUP#	
INSURANCE ADDRESS (BACK OF CARD)	
PHONE # FOR PROVIDERS	
SECONDARY	
COMPANY	
SUBSCRIBER'S NAME	
RELATIONSHIP TO CHILD	
SUBSCRIBER'S BIRTHDATE	
SUBSCRIBER'S SOCIAL SECURITY	
SUBSCRIBER'S EMPLOYER	
CERTIFICATE #	
GROUP#	
INSURANCE ADDRESS (BACK OF CARD)	
PHONE # FOR PROVIDERS	

Name:_____DOB:_____

MEDICAL HISTORY

- ☐ Premature: Born at _____weeks gestation.
- ☐ Pregnancy Complications?_____
- ☐ Full-Term
- ☐ Overdue by _____weeks
- ☐ Birth Complications? _____

Birth Weight: _____lbs. _____oz.

	Please check any complications your child has had.	**Specific information**
	Jaundice/Bili Light	
	Stay in NICU	
	Oxygen	
	Feeding Tube	
	Transfusion	
	IV	
	Fever	
	Difficulty Feeding	
	Colicky	
	Difficulty Sleeping	
	Slow To Meet Milestones	
	Reflux	
	Allergies	
	Hospitalized	
	Diagnostic Testing (CAT scan, MRI, blood work)	
	Ear Infections	
	Frequency	
	Age	
	Hearing Evaluated	
	Other	

Skill	**Age Acquired**	**Comments**
Rolling Over		
Sitting		
Crawling		
Walking		
Self-feeding		
Toilet-trained		
Climbing Stairs		
Dressing Self		
Babbling		
Said First Real Words		

Name:_____DOB:_____

ADDITIONAL INFORMATION

Parents/Guardian's Marital Status: ___Single ___Married ___Divorced ___Separated ___Partnering

Child's Brothers & Sisters: (names and ages) _____

Is there any special information regarding your child's health of which we should be aware? (Allergies, illnesses, seizures, other health/physical conditions):_____

Are there any problems of adjustment of which we should be aware?_____

What would you like us to know about your family traditions, holidays, culture and celebrations? _____

Is there any other information, which would further contribute to a better understanding of your child? (Fears, jealousy, dependency on others, etc.)_____

What special interests and activities does your child enjoy?_____

What do you hope your child gains from coming to therapy?_____

Please list provider(s) who is or has been involved with your child.

Role	**Name**	**Ok to share information?**	
		Yes	**No**
Occupational Therapy			
Physical Therapy			
Speech Therapy			
Specialized Instruction			
Play Therapy			
Case Management			
Counseling			
Child Care Provider			
Counselor			
Psychologist			
Psychiatrist			
Developmental Pediatrician			
Other			

Name:_____DOB:_____

CHILD'S STRENGTHS/CHALLENGES

Please identify your child's strengths and areas that you have concerns about:

	Strength	Challenge	Comments
Fine Motor			
Gross Motor			
Thinking Skills			
Sensory Skills			
Social Skills			
Self-care Skills			
Feeding/Eating Skills			
Sleeping			
Attention/Focus			
Communication			
Vision			
Hearing			
Academic Skills			
Behavior			

Eating/Feeding Habits:

- ☐ Eats a wide variety of foods
- ☐ Eats regular foods
- ☐ Eats purees
- ☐ Eats chunky foods
- ☐ Eats dry foods
- ☐ Uses utensils
- ☐ Prefers to eat with hands
- ☐ Drinks from bottle or breast
- ☐ Drinks from an open cup
- ☐ Drinks from a sippy cup
- ☐ Drinks from a straw
- ☐ Is a messy eater
- ☐ Is Tubefed
- ☐ Has issues with textures
- ☐ Has issues with temperature
- ☐ Has issues with taste or type
- ☐ Eats meals/snacks on a regular schedule
- ☐ Eats small amounts frequently
- ☐ Eats being held
- ☐ Eats in a high chair/feeding chair
- ☐ Eats while moving about the environment
- ☐ Eats at the table with others

Other Information:

Sleep Habits

- □ Naps (_____hours/day)
- □ Sleeps through the night
- □ Difficulty falling asleep
- □ Frequent awakenings
- □ Has a sleep object (blanket/stuffie, etc.)
- □ Uses a bottle/cup/pacifier to fall asleep

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

Please sign below and return so that we know you have been offered our *Notice of Privacy Practices*.

I acknowledge receipt of the *Notice of Privacy Practices* prepared by Honeybee Pediatric Therapy, LLC.

_____

Name of Client

_____

Signature of Parent or Legal Guardian

_____

Parent or Legal Guardian (Please Print)

_____

Date