SALUS UNIVERSITY
Occupational Therapy Institute

Pediatric Intake Form

Client Information

Full Name: _____
Preferred Name: _____
Today's Date: _____
Date of Birth (dd/mm/yyyy): _____
Sex: _____

Check one or more options for the set(s) of pronouns you want people to use to refer to you:

- ❑ he, him, his
- ❑ she, her, hers
- ❑ they, them, theirs
- ❑ sie, hir, hirs
- ❑ Other: _____

Preferred Spoken/Written Language

- ❑ English
- ❑ Spanish
- ❑ American Sign Language
- ❑ Other:

Language interpretation services needed?

- ❑ No
- ❑ Yes, language: _____

This section is optional to complete:

Are you of Hispanic, Latino, or of Spanish origin? ❑ Yes ❑ No

How would you describe yourself? Check all that apply.

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ From multiple races
- ❑ Other: _____

Preferred Mailing Address:_____
Child's Grade: _____
Child's Daycare/School: _____
Current Therapy Services: _____
History of Therapy Services: _____

Current Diagnosis (if any): _____

Guardian Information

Parent/Guardian #1 Name:_____
Relationship to child:_____
Email:_____
Home Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Work Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Cell Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Address (if different from child):

Ok to disclose medical information ❑ Yes ❑ No
Ok to pick child up from therapy ❑ Yes ❑ No

Parent/Guardian #2 Name: _____
Relationship to child: _____
Email:_____
Home Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Work Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Cell Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Address (if different from child):

Ok to disclose medical information ❑ Yes ❑ No
Ok to pick child up from therapy ❑ Yes ❑ No

Parent/Guardian #3 Name: _____
Relationship to child:_____
Email:_____
Home Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Work Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Cell Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Address (if different from child):

Ok to disclose medical information ❑ Yes ❑ No
Ok to pick child up from therapy ❑ Yes ❑ No

Doctor Information

Pediatrician's Name:_____
Pediatrician's Phone Number:_____

Referral Information
Who referred you/client to our clinic? _____
Reason for referral: _____
What are your primary concerns?

_____
_____
_____

What do you hope to accomplish with therapy services?

_____
_____
_____

Does the client currently have any diagnosis? Please list:

_____
_____
_____

Has the client had any injuries, surgeries, illnesses or hospitalizations? Please list:

_____
_____
_____

Emergency Information Sheet

- ❑ **Check if the same as Guardian listed above**

Client Full Name:_____ Birth date:_____ Phone Number:
Contact Name: _____ Relation: _____
Work Phone Number: _____ Cell Phone Number: _____

If client becomes ill or involved in an accident and an emergency contact cannot be reached, I authorize the following hospital or above-named physician to give the emergency medical treatment required:
Hospital: _____ Address: _____
Parent/Guardian Full Name: _____
Parent/Guardian Signature: X_____
Date:_____

Medical History
How is the client's health general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

When was your last comprehensive medical evaluation? _____
Do you have any allergies to medications or other substances (pets, food, etc.)? ❑ Yes ❑ No
If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Please check any of the following diagnoses which apply to the client:

- ❑ Developmental Disorder
  - ❑ Autism Spectrum Disorder
  - ❑ Down Syndrome
  - ❑ Developmental Delays
  - ❑ Sensory Processing Disorder
  - ❑ ADHD
  - ❑ Intellectual and Learning Disabilities
    - ❑ Dyslexia
    - ❑ Dyscalculia
    - ❑ Dysgraphia
  - ❑ Other:_____
- ❑ Pulmonary and Cardiac Conditions
  - ❑ Cystic Fibrosis
  - ❑ Asthma
  - ❑ Tetralogy of Fallot
  - ❑ Other:_____
- ❑ Musculoskeletal
  - ❑ Muscular Dystrophy
  - ❑ Juvenile Rheumatoid Arthritis
  - ❑ Scoliosis
  - ❑ Congenital Limb Differences
  - ❑ Other:_____
- ❑ Psychosocial
  - ❑ Anxiety
  - ❑ Depression
  - ❑ Obsessive Compulsive Disorder (OCD)
  - ❑ PICA
  - ❑ Eating Disorder
  - ❑ Emotionally or behaviorally disturbance
  - ❑ Other:_____
- ❑ Neurological Disease/Disorder
  - ❑ Head Injury/Concussion
  - ❑ Epilepsy or other seizure disorder
  - ❑ Cerebral Palsy

- ❑ Spina Bifida
- ❑ Spinal Cord Injury
- ❑ Other:_____

❑ Diabetes
- ❑ Type 1
- ❑ Type 2

❑ Obesity

❑ Cancer
- ❑ Type/location:_____

❑ Visual Impairment

❑ Auditory impairment

❑ Pain

❑ Sleep problems

❑ Other: _____

Does the client currently take any medications/supplements/vitamins? Yes No

Medications:

_____
_____
_____

Supplements:

_____
_____
_____

Is there anything else you would like your occupational therapist to know before your evaluation or screening (ex. prior developmental difficulties, medical complications, personal preferences)?

_____
_____
_____

Thank you for providing this information
Additional comments/personal or family history:

_____
_____
_____

Optional:
Do you think anyone else in your household/residence would benefit from services?

- ❑ No
- ❑ Yes
    - ❑ If so please list, _____

Thank you for providing this information
Additional comments/personal or family history:

_____
_____
_____

____Notice of Client Rights & Responsibilities: I acknowledge that I have received and read a copy of the Client Rights and Responsibilities form.
____Notice of Privacy Practices: I acknowledge that I have received and read a copy of the Notice of Privacy Practices that describes my rights regarding my health information and how my health information may be used or disclosed.
____Authorization to Release Medical Information: I authorize the Occupational Therapy Institute to release my medical information to my referring physician, nurse practitioner, or other clinicians involved in my treatment in order to coordinate care.
____Consent to Treat: I give my consent to the Occupational Therapy Institute students and licensed supervisors to provide outpatient therapy services considered necessary and proper for my diagnosis. I understand that I may refuse treatment at any time. My initials above and my signature below indicate consent to all of the above.
____Consent to Treat: I understand that I can be treated at the Occupational Therapy Institute for two consecutive semesters, followed by a break in care for one semester. This is to provide equity for other patients on the waitlist, and to provide patient diversity for student learning. If appointments become available during my break period, I may be offered another evaluation as time allows.
____ Consent to Treat: I understand that I need a new prescription every semester (January, May, and September) to continue my plan of care at the Occupational Therapy Institute.
____ Consent to Treat: I understand that I may be discharged from the Occupational Therapy Institute if more than three sessions in a three months period are canceled or not attended (i.e. no show) without notice to the clinic staff.

Release for educational and teaching purposes
I, _____, authorize the therapists at the Occupational Therapy Institute, to be observed and or receive therapy during sessions by fieldwork students/interns and/or volunteers in our usual practice. I understand that these individuals will be signing confidentiality agreements as mandated by HIPAA and that any information will be used for teaching purposes only.

Signature: _____

Patient Name:_____
Date:_____