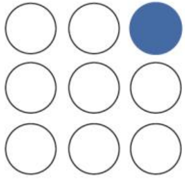

SO MANY OPTIONS. ONLY ONE SPOT TO BE.

30903 W. 10 Mile Rd Suite B
Farmington Hills MI 48336
Ph: (248) 893-6192
Fax: (248) 457-5490
www.therapyspotmi.com

Date: _______________

New Patient Intake Form

Patient Information

Patient Name: _____________________________________ DOB: _____________ Age: ________ Gender: __________
Name of Person Completing Form: ____________________________________ Relationship to Patient: _____________
Does patient live with both parents: Yes No Primary Language spoken: _________________________________
How did you hear about the Therapy SPOT? ____

Contact Information

Mailing Address: ____________________________________ City/State: _________________________ Zip Code: ________
Home Phone #_______________________ Cell Phone # ________________________ Work Phone # _________________
Best Times to Call: (home) ____________________ (cell) _______________________ (work) ________________________
Email address: ______________________________________ Preferred Method of Communication: Home Cell Work
Emergency Contact (name and relationship if applicable): ______________________________ Ph # _________________

Please list additional person(s) who will be involved with child's therapy:

Name	Relationship	Phone #

Insurance

Name of Person Insured: _____________________________ Relationship to Patient: ______________ Birthdate: ___________
SS# _______________________ Occupation: ____________________________ Employer: ______________________________
Employer Address/Phone # ____
Primary Insurance: _____________________________ Group Number: ________________ Contract #: ____________
Secondary Insurance: ____________________________ Group Number: _______________Contract #: _______________

Patient Name: ___________________________

Health and Medical History

Please list any known allergies: ____

Please list any known or suspected diagnoses or medical precautions: ____________________________

Primary Concern/reason for today's visit: ____________________________________

Please list any medications/vitamins and quantity: _______________________________

____

Is your child currently on a special diet or have any food restrictions? Yes No ______________________

Tests/Procedures/Surgeries (list additional on back of page):

Test/Procedure	Reason	Date	Results
Vision			
Hearing			

Length of Pregnancy: ______ weeks Child was delivered: ___ vaginally ___ C-Section ___ unknown/NA

Delivery complications? Yes No (please list) ____________________________________

Complications following birth? Yes No (please list) ____________________________________

Days in Hospital: ________ Birth Weight: ___ lbs ____ oz

Name of Referring Physician: ______________________________ Phone # ___________________

Other Physicians and Specialists (i.e.: pediatrician, neurologist, psychologist):

Type	Name	Reason

Past/Current Therapy Services

Type	Frequency	Location	Dates	Current?
EX: Speech therapy	1x/week	school	1/2012-1/2013	Y N
				Y N
				Y N
				Y N
				Y N

Patient Name: ___________________________

School

Name of School: ____ Grade: ___________

Does Child have an IEP? Yes No If yes, what areas are being addressed: _______________________________

____

Does child receive any accommodations to be successful in school (if yes, please list): Yes No

Please list/explain any concerns or difficulties child demonstrates in the school environment:

____

____

____

Development

Speech/feeding milestone	months	Speech/feeding milestone	months
Names familiar objects	____________	*Eats baby food*	____________
Uses 2 word combination	____________	*Eats junior food*	____________
Uses complete sentences	____________	*Eats table food*	____________
Uses a bottle	____________	*Uses cup, sippy cup*	____________
Uses a pacifier	____________	*Uses straw*	____________

Motor milestone	months	Motor milestone	months
Holds head up alone	____________	*Creeps/crawls alone*	____________
Grabs toys	____________	*Pulls self to standing*	____________
Rolls over	____________	*Walks unaided*	____________
Sits alone	____________		____________

How does child get around the house? _______________ Does child easily lose balance or fall? Yes No

Please list child's favorite toys and/or play activities: ____

What were child's first words? ____ At what age? ___________________

Speech & Feeding

Current speech concerns: ____

How does your child communicate (check all that apply)?

☐ Body language/facial expressions ☐ Single words ☐ Sentences longer than 4 words ☐ Non-verbal
☐ Eye gaze ☐ Sign Language ☐ Gesturing/pointing ☐ Sounds (vowels, grunts)

Does your child use an Augmentative Communication Device? If yes, please list: ___________________________________

Does your child:

Repeat sounds, words, or phrases over and over?	Yes	No
Understand what you are saying?	Yes	No
Retrieve or point to common objects upon request?	Yes	No
Follow simple directions ('shut the door' or 'get your shoes')?	Yes	No
Respond correctly to yes/no questions?	Yes	No
Respond correctly to who/what/where/when/why questions?	Yes	No
Have trouble describing events or thoughts?	Yes	No

How much of your child's speech do you understand?	0%	25%	50%	75%	100%
How much do unfamiliar listeners understand?	0%	25%	50%	75%	100%

Patient Name: ___________________________

Activities of Daily Living (ADL)

Please indicate the amount of assistance your child needs with the following tasks:

Task						
Puts on shirt/pants:	0%	25%	50%	75%	100%	N/A
Puts on socks/shoes:	0%	25%	50%	75%	100%	N/A
Unbuttons, unsnaps, unzips:	0%	25%	50%	75%	100%	N/A
Brushes teeth:	0%	25%	50%	75%	100%	N/A
Toileting:	0%	25%	50%	75%	100%	N/A
Zips jacket:	0%	25%	50%	75%	100%	N/A
Ties shoes:	0%	25%	50%	75%	100%	N/A
Wipes after toileting:	0%	25%	50%	75%	100%	N/A
Bathing, washing hair	0%	25%	50%	75%	100%	N/A
Cuts with knife and fork:	0%	25%	50%	75%	100%	N/A
Uses utensils during meals:	0%	25%	50%	75%	100%	N/A
Removes clothing:	0%	25%	50%	75%	100%	N/A

Please note any additional concerns regarding child's ability to be independent in his or her daily routine:
____
____

Additional Concerns

If you have sensory concerns, please complete the "Sensory History Checklist" provided.
If you have feeding concerns, please complete the "Feeding and Mealtime Assessment" provided.

The information provided in this form helps our therapists tailor the evaluation to meet the needs of your child, so thorough responses are appreciated. Any additional concerns or comments, please note them below:

THE THERAPY SPOT
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