



THE
THERAPY
SPOT

SO MANY OPTIONS. ONLY ONE SPOT TO BE.

To Schedule:
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30903 W. 10 Mile Rd Suite B
Farmington Hills MI 48336

675 E. Big Beaver Rd. Suite 201
Troy, MI 48083

www.therapyspotmi.com

Date: _____

New Patient Intake Form

Please Circle Your Preferred Location

675 E. Big Beaver Rd Suite 201
Troy, MI 48083

30903 W. 10 Mile Rd. Suite B
Farmington Hills, MI 48336

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
<i>Vision</i>			
<i>Hearing</i>			

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?
<i>EX: Speech therapy</i>	<i>1x/week</i>	<i>school</i>	<i>1/2012-1/2013</i>	<i>Y N</i>
_____				<i>Y N</i>
_____				<i>Y N</i>
_____				<i>Y N</i>
_____				<i>Y N</i>

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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
<i>Names familiar objects</i>	_____	<i>Eats baby food</i>	_____
<i>Uses 2 word combination</i>	_____	<i>Eats junior food</i>	_____
<i>Uses complete sentences</i>	_____	<i>Eats table food</i>	_____
<i>Uses a bottle</i>	_____	<i>Uses cup, sippy cup</i>	_____
<i>Uses a pacifier</i>	_____	<i>Uses straw</i>	_____

Motor milestone	months	Motor milestone	months
<i>Holds head up alone</i>	_____	<i>Creeps/crawls alone</i>	_____
<i>Grabs toys</i>	_____	<i>Pulls self to standing</i>	_____
<i>Rolls over</i>	_____	<i>Walks unaided</i>	_____
<i>Sits alone</i>	_____		_____

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: _____

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

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:

Goals for Therapy

Please list at least 3 goals per discipline that you hope to achieve with the help of therapy:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Additional Concerns

- I have concerns about my child's sensory processing (Please Complete: Sensory History Checklist)
- I have concerns about my child's feeding/eating (Please Complete: Food and Mealtime Assessment)
- Check this box if you would like to discuss your child's concerns in greater depth via a phone interview. Be sure you have noted a good time to call you in the Contact Section above. You will be contacted at some point before your child's evaluation. If you prefer, you may describe any additional concerns/information below: