Fidalgo Island Pediatric Occupational Therapy

Empowering children and families
Anacortes, WA 98221
Email: fidalgoislandot@therapysecure.com
Phone: (206) 794-6030

INTAKE FORM

Child's Name:

Date of Birth:

Preschool/Grade in School:

Does your child have an IEP at School? Yes_____ No_____

Parent/Guardian Information

Parent/Guardian Names (List all who will be involved in the child's therapy)

Name	Relationship	Phone	Email Address
1.			
2.			
3.			

____ Check here if it is ok to call all parties listed above
____ Check here if it is ok to leave messages for all parties listed above
____ Initial here: I understand that email, cell phone, & fax communication are not always secure modes of communication and I accept this potential privacy risk. I may revoke this consent at any time in writing.
Make a checkmark next to phone(s) or email(s) to use for appointment reminders

What are your primary concerns regarding your child's development?

What kinds of things does your child like to do/enjoy? What are some of your child's interests?

What is your child's birth history? (list any complications, areas of concern, etc.)

Please list any medical diagnoses given to your child (Down Syndrome, Cerebral Palsy, Autism, reflux, allergies, etc.):

Any allergies/food sensitivities?

Are there any medical restrictions or medical precautions that apply to your child?

Please list other specialists or facilities where your child is followed (Children's Hospital, Ear, Nose and Throat, WICC, Neurologist, etc.)

Has your child had any significant illness, injury, surgeries or hospitalization(s) that we should be aware of?

Please indicate any recent testing (MRI, swallow study, x-rays, hearing test, ADHD, IQ, genetic testing, etc.)

Do you have any concerns about your child's hearing or vision?

Please list any medications your child takes:

Was your child late to meet any of their developmental milestones? (sitting, crawling, walking, speaking, toilet training, feeding, reading, etc.)

Has your child had any previous evaluations? (physical therapy, occupational therapy, speech therapy, feeding, school, etc.)? Please list where and approximate dates.

What are your child's strengths?

What are you hoping to gain from occupational therapy?

Insurance Information

Party Responsible for Payment		Date of Birth	
Address		Phone	
Occupation		Employer	
Primary Insurance Company		Phone Number	
Policy #		Group #	

Are you covered by more than one insurance company? If so, list:

We will request photocopies, front and back, of insurance cards.

Parent/Guardian Signature_____

Date_____