SENSATIONAL KIDS | the place for pediatric therapy

Date: _____

DEVELOPMENTAL INTAKE ASSESSMENT

The information you provide will help our staff determine the care you need and the tests administered during your child's evaluation. A child's individual background, cultural experience, and family support are important factors in determining a treatment plan for your child.

Therapy Services Needed (Check all that apply):

☐ Speech-Language ☐ Occupational ☐ Physical ☐ Feeding (circle OT or SLP)

Service Location (Check preferred location)

☐ Edmond- 14715 Bristol Park Blvd, Edmond OK 73013

☐ Sooner- 901 S. Sooner Road, Oklahoma City, OK 73110

☐ Yukon- 1445 Health Center Parkway, Yukon OK 73099

General Information:

Child's Name: _____ Gender/Pronoun: _____ Date of Birth: _____

Parent/Caregiver Names: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell: _____

Best # to call: (please circle one) Home / Business / Cell Email address: _____

Native Language(s) spoken in the home: _____ Primary language of child: _____

Emergency contact name and phone number: _____

Who referred you to Sensational Kids? _____

Who is your child's Pediatrician or Family Doctor? _____

Address: _____ Phone: _____ Fax: _____

Is your child in school? Yes or No If yes, where? _____

What grade? _____ Is child in any special classes or have special needs? _____

Does your child have an IEP? Yes or No **If yes, we need a current copy returned with this form**

Reason for visit:

Briefly state the reason your child needs an evaluation (include reasons for each evaluation if seeking more than one service) _____

_____

_____

When were the problems first identified? _____ By whom? _____

Is your child aware of the problem? If so, how does the child feel? _____

Child / Family Concerns and Goals:

Please describe what you want your child to achieve with the help of therapy (What would you like your child to do that they can't do now?)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Family Information:

Parent/Caregiver: _____ Date of birth:_____
Occupation: _____ Highest Educational Level: _____
Relationship to child: _____ (please circle): Biological Adoptive Step Foster Other

Parent/Caregiver: _____ Date of birth: _____
Occupation: _____ Highest Educational Level: _____
Relationship to child: _____ (please circle): Biological Adoptive Step Foster Other

Please list siblings and/or anyone else that lives in the home:

NAME	AGE	RELATIONSHIP TO THE CHILD
1		
2		
3		
4		
5		

Does your child have a caregiver outside of the home? _____
If yes, when is child with this caregiver? _____

Is there anything about your beliefs we should know that may impact therapy or activities chosen for therapy? (ex. holiday worksheets)

_____

Is your child on a specific or special diet? (ex. gluten, casein, food coloring, sugar) _____

_____

What are your child's favorite activities, things to eat, and/or cartoons, which can be used as motivators during therapy? (ex. Bluey, Paw Patrol, CoComelon, Star Wars, Goldfish, pretzels, Skittles)

_____

_____

What activities does your child participate in regularly? (ex. soccer, church, gymnastics)

_____

What is your child's main form of mobility? (ex. crawl, walk, wheelchair/stroller)

_____

Medical History:

Were there any complications during pregnancy or delivery of your child? _____
If yes, please describe: _____
Gestational age at time of delivery (or # of weeks early or late): _____
What type of delivery (please circle one)? Vaginal Cesarean Section: elective or emergency
Birth Weight: _____ Length: _____ Was your child in the NICU? _____
If yes, how long and why? _____

Please make sure to include an explanation for any questions answered "yes."

ITEM	DESCRIPTION	YES	NO	EXPLANATION
1	Frequent Colds/Respiratory Illness			
2	Frequent Strep throat/sore throat			
3	Frequent Ear Infections (tubes placed?)			
4	Birth defect/genetic disorder			
5	Allergies or asthma			
6	Heart condition			
7	Visual disorder/vision problems			
8	Neurological disorder			
9	Seizures or convulsions			
10	Hearing Loss/Ear disorder			
11	Head injuries or concussions			
12	Any major childhood illness (pox, croup, measles, mumps, meningitis etc.)			
13	Hospitalization/surgery			

Does your child see any specialists? (ex. neurology, psychiatrist, counseling, ABA, etc.)
_____

Has your child had any difficulties with feeding? (ex. sucking, swallowing, drooling, chewing, reflux, choking)
Yes___ No___ If yes, describe: _____
Does your child have a tongue, lip, or cheek tie? Yes___ No___ Suspected___ Revised___ Unknown___

Does your child have difficulty keeping up with friends?
Yes___ No___ If yes, describe: _____

Does your child trip/fall often?
Yes___ No___ If yes, describe: _____

List current medications your child is taking, if any (please include any over-the-counter medications or medications given as needed): _____
_____

***Please note: If medications change at any time before evaluation or services begin, please provide written documentation to include in your child's records.**

Is your child ALLERGIC to any foods?
Yes ___ No ___ If yes, what? _____
Please list reactions to allergy along with severity: _____

Is your child ALLERGIC to any medications?
Yes ___ No ___ If yes, what? _____
Please list reactions to allergy along with severity: _____

Does your child use any special equipment? (ex. glasses, hearing aide, splints, wheelchair) Yes___ No___
If yes, please list: _____

Developmental History:

Please mark whether your child accomplished the milestone Early, On Time, Late or it is not applicable (N/A).

MILESTONE	EARLY	ON TIME	N/A	LATE	IF LATE, WHAT AGE?
Said first words (Avg. 6-12 months)					
Used simple questions (Avg. 18-24 months)					
Followed simple commands (Avg. 9-12 months)					
Said 2-3 phrases (Avg. 18-24 months)					
Lifted head when on tummy (Avg. 0-3 months)					
Rolled Over (Avg. 3-6 months)					
Sat unsupported (Avg. 6-7 months)					
Crawled (Avg. 6-9 months)					
Stood Unsupported (Avg. 10-12 months)					
Walked by self (Avg. 12-14 months)					

Please check the tasks your child can do independently at this time:

Drinks from: ___Bottle ___Spouted or special cup ___Straw ___Regular cup ___ Blows out candles
Feeds Self: ___Finger feeds ___Eats with spoon ___Eats with fork ___Cuts with knife
Brushes teeth: ___Tolerates parent ___Attempts to brush, but requires assistance ___Brushes independently
Undresses: ___Shirt ___Pants ___Underwear ___Socks ___Shoes
Dresses: ___Shirt ___Pants ___Underwear ___Socks ___Shoes
Shoelaces: ___Ties shoelaces ___Fastens Velcro shoes
Buttons: ___Opens large PJ buttons ___Opens small dress shirt buttons
___Fastens small dress shirt buttons ___Opens button on top of pants
Zippers: ___Pulls down to open ___Pulls up once pin is placed by adult ___Places pin and pulls up
Bladder: ___Trained days ___Trained nights ___Bowel trained
Sleeps: ___Sleeps all night ___Wakes up frequently
___Needs special routine (ex. music, light etc.) If yes, please explain routine:
_____
_____

Does your child demonstrate any of the following that is not expected for their age?

ITEM	DESCRIPTION	YES	NO	EXPLANATION
1	Drooling			
2	Thumb sucking			
3	Temper tantrums/Meltdowns			
4	Head banging			
5	Aggression/destructiveness			
6	Nervous habits (nail biting, etc.)			
7	Under or over reactive to sounds			

ITEM	DESCRIPTION	YES	NO	EXPLANATION
8	Under or over reactive to clothing or touch			
9	Under or over reactive to taste			
10	Under or over reactive to smell			
11	Unusual fears			
*12	Difficulty socializing with peers			
*13	Difficulty socializing with family			
14	Difficulty remaining in car seat			

***If you marked yes to questions 12 or 13, please complete the next section "Social." If not, please continue on to "Family Stressors."**

Social:

Please place check mark next to any social skill in which your child demonstrates difficulty:

____Initiating/responding to greetings/farewells of peers ____Sustaining activities with peers
____Maintaining the "give and take" of conversations ____Initiating conversations with peers
____Responding to questions during conversation ____Asking questions during conversation
____Maintaining eye contact during conversation ____Expressing verbally how they are feeling
____Recognizing facial expressions, non-verbal cues, or "body language" of others

Family Stressors: (please note if any of the following stressful events happened in the last 12 months)

ITEM	DESCRIPTION	YES	No	EXPLANATION
1	Marital separations/divorce			
2	Death in the family			
3	Financial crisis			
4	Job change/difficulties			
5	School problems			
6	Legal problems			
7	Medical problems			
8	Household move			
9	Extended separation from parents			
10	Other stressful event			

Speech and Language: (please complete this portion ONLY IF you have concerns regarding your child's speech and/or language skills; those seeking Occupational Therapy or Physical Therapy continue to ** below)

Which of the following do you think your child understands?

____Their own name ____Family names ____Names of objects ____Names of body parts
____Simple directions ____Complex directions ____Conversational speech

What methods does your child use for letting you know what they want?

____Looking at objects ____Pointing at objects ____Gestures ____Crying ____Vocalizing/grunting
____Physical manipulation ____Single words ____2-3 word combinations ____Sentences

Which of the following describes your child's speech?
____Easy to understand ____Difficult for parents to understand ____Difficult for others to understand
____Almost never understood by others ____Different from other children of the same age

Which of the following describes your child's reaction to their speech?
____Is easily frustrated when not understood
____Does not seem aware of speech/communication problem
____Has been teased about their speech
____Tries to say sounds or words more clearly when asked

If your child is not yet using words, do they produce any sounds? Yes or No If yes, which sounds? _____
Does your child have difficulty producing certain sounds? Yes or No If yes, which sounds? _____
Does your child stutter when attempting to say a word? Yes or No
Do you have concerns about your child's voice? (too soft, too loud, etc.) Yes or No
What is your reaction to your child's speech? _____
_____
_____
Describe your child's current communication status (ex. verbal, sign language, communication device):
_____

****Has your child been evaluated or received therapy this calendar year, here or at any another facility?**
YES ____ NO ____ (If yes, please speak with the front office regarding transferring the evaluation and/or units.)

If yes, please list below:

	Who	*Where*	*When*
Occupational Therapy			
Physical Therapy			
Speech-Language Therapy			
Feeding Therapy (circle OT or SLP)			

Focus and outcomes of above therapies: _____
_____

Billing Information for Accepted Insurance Carriers:
For occupational therapy, physical therapy, and speech-language therapy we are currently in-network providers for:

- Blue Cross/Blue Shield, Tricare, HealthChoice, OSMA and Medicaid/Soonercare, United Healthcare, Web TPA, and Cigna.

If you are a member of one of these providers, we will file the insurance claims for you. **Co-payment is due the day of service.** If services are not covered for any reason by your insurance company, you will be responsible for the payment in full.

Billing Information for Out-of-Network Insurance Carriers:
If we are out-of-network with your insurance company, full payment of service is due the day of service. We will submit a claim on your behalf as a courtesy. Depending on your insurance plan, out-of-network benefits may be payable after your deductible is met. Some carriers will reimburse you directly, while others will reimburse the

clinic. If the clinic is reimbursed the amount will be credited to your account and future payments for services will be adjusted accordingly. Written reports will be provided upon request of insurance company as needed.

Primary Insurance Information:

Insurance Co. Name: _____ Phone# _____
Group # _____ ID # _____
Name of Sponsor: _____ Employer's Name: _____
Sponsor SSN# _____ Sponsor DOB: _____
*If policy holder lives with patient, please check this box [ ]
*If policy holder does not live with patient, please provide address of policy holder

Secondary Insurance Information:

Insurance Co. Name: _____ Phone# _____
Group # _____ ID # _____
Name of Sponsor: _____ Employer's Name: _____
Sponsor SSN# _____ Sponsor DOB: _____
*If policy holder lives with patient, please check this box [ ]
*If policy holder does not live with patient, please provide address of policy holder

Billing Information for Private Pay Therapy:

If we are not in network with your insurance carrier or if the service(s) are a non-covered benefit from your insurance provider we do offer a "Same Day Discount Price." To qualify for this discounted price, the payment must be made the day of service.

The initial evaluation fee of $350.00 includes an evaluation and a written report. If standardized testing is not required, a consultation fee of $200.00 will provide a one-hour consultation and a written report with treatment goals. Occupational and physical therapy treatment sessions are $120.00 for a 60-minute session. Speech-language therapy treatment sessions are $60.00 for a 30-minute session or $100.00 for a 60-minute session. 60-minute speech-language therapy sessions are at the discretion of the caregiver and therapist, based on child's needs. Additional services provided include attending an IEP meeting ($125.00) and performing school or home observations for up to 90-minutes ($150.00). **All payments are due at the time of service(s) to qualify for these discounted prices.**

Financial Responsibility:

Individual who is financially responsible for this account:

Name: _____
DOB: _____
SSN: _____

- By signing this form I declare that I am the legal guardian of this minor and allowed by law to make decisions for testing this child. If my insurance or any other information changes prior to the evaluation or during the time my child receives therapy treatment it is my responsibility to provide written changes to Sensational Kids, Inc. (ex. new insurance information, home address, phone number)

- I understand I am financially responsible for services rendered by Sensational Kids, Inc. and staff, and I understand that my insurance plan may pay a negotiated portion of these charges. I authorize my insurance company to pay benefits directly to Sensational Kids, Inc.

- I understand that in the event my insurance denies payment for services rendered, for my child, I agree to be personally responsible for those charges. I understand all co-pays designated by the insurance plan contract are my responsibility and are due at the time of my child's office visit. In the event my account is referred to a collection agency for payment, I will be responsible for any fees associated with collection of this debt. If my check is returned for insufficient funds, I will be charged a returned check fee of $25.00.

Signature: _____ Date: _____

Attendance Policy:

Since children and other family members understandably get sick, Sensational Kids will attempt to reschedule the appointment. In the event that the appointment is not rescheduled, Sensational Kids allows two cancellations per quarter (a three month period). If a family needs to cancel additional sessions during the quarter, the sessions MUST be rescheduled or your child will be removed from their reoccurring appointment.

Release of Information:

Sensational Kids may disclose any or all of the patient's information for insurance claim purposes. If another party is paying the patient's bill, Sensational Kids may then disclose any or all of the patient's information to that party to verify charges. Sensational Kid may disclose any or all of the patient's information to the patient's attending physician, consulting physician(s), and other health care providers who have a legitimate need for such information in the care and treatment of the patient.

Setting up Initial Evaluation:

As soon as completed paperwork is received at our office and insurance benefits are verified, Sensational Kids will contact you to schedule an evaluation. If you have not received a call within two weeks of returning the paperwork, please contact our office. On the day of your child's evaluation, please have your child wear socks, shoes, and corrective lenses, if needed. We look forward to meeting you soon!

By signing this form you agree to all the terms and conditions listed above.

Parent/Caregiver
(Please Print Name): _____ Signature: _____ Date: _____