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)

___Occupational ___Speech-Language ___Physical ___Feeding (circle OT or SLP)

Service Location (Check preferred location)

___Edmond Main: 14715 Bristol Park Blvd., Edmond, OK 73013
___Edmond Covell: 3933 East Covell Road, Edmond, OK 73034
___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: _____
Native language(s) spoken in the home: _____ Primary language of child: _____
Is your child in school? ___Yes ___No If yes, where? _____
What grade? _____ Does your child have any special classes or special needs? ___Yes ___No
Does your child have an IEP? ___Yes ___No **If yes, we need a current copy returned with this form.**

Parent/Caregiver 1: _____ Date of birth: _____
Relationship to child: _____ ___Biological ___Adoptive ___Step ___Foster ___Other
If parent/caregiver is not the biological parent, is the child aware? ___Yes ___No
Home address: _____ City: _____ State: _____ Zip: _____
Home phone: _____ Business phone: _____ Cell phone: _____
Best # to call: ___Home ___Business ___Cell Email address: _____
Social security number: _____ Occupation: _____
Employer: _____ Employer phone: _____

Parent/Caregiver 2: _____ Date of birth: _____
Relationship to child: _____ ___Biological ___Adoptive ___Step ___Foster ___Other
If parent/caregiver is not the biological parent, is the child aware? ___Yes ___No
Home address: _____ City: _____ State: _____ Zip: _____
Home phone: _____ Business phone: _____ Cell phone: _____
Best # to call: ___Home ___Business ___Cell Email address: _____
Social security number: _____ Occupation: _____
Employer: _____ Employer phone: _____

Emergency contact name and number (different from above caregivers): _____
Who is your child's pediatrician or family doctor? _____
Address: _____ Phone: _____ Fax: _____

Reason for Visit:

Who referred you to Sensational Kids, Inc.? _____
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 your 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. _____

Additional Child/Family Information:

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

NAME	DOB	RELATIONSHIP TO THE CHILD
1.		
2.		
3.		
4.		
5.		
6.		

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

Is there anything about your beliefs we should know that may impact therapy or activities chosen for therapy (*e.g.*, holiday worksheets)? ___Yes ___No
If yes, please describe: _____

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

What activities does your child participate in regularly (*e.g.*, soccer, church, gymnastics)? _____
_____

Medical History:

Were there any complications during your child's pregnancy or delivery? ___Yes ___No
If yes, please describe: _____
Gestational age at time of delivery (or # of weeks early or late): _____

What type of delivery? ___Vaginal ___Cesarean Section: ___Elective ___Emergency
Birth weight: _____ Length: _____ Was your child in the NICU? ___Yes ___No
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 (*e.g.*, pox, croup, measles, mumps, meningitis)			
13.	Hospitalization/surgery			

Does your child see any specialists (*e.g.*, neurology, psychiatrist, counseling, ABA)? ___Yes ___No
If yes, please describe: _____

Has your child had feeding difficulties (*e.g.*, sucking, swallowing, chewing, reflux, choking)? ___Yes ___No
If yes, please describe: _____
Does your child had a limited diet of foods? ___Yes ___No
If yes, please describe: _____
Does your child have a tongue, lip, or cheek tie? ___Yes ___No ___Suspected ___Revised ___Unknown

What is your child's main form of mobility (*e.g.*, crawl, walk, wheelchair/stroller)? _____
_____
Does your child trip/fall often? ___Yes ___No ___N/A
If yes, please describe: _____
Does your child have difficulty keeping up with friends? ___Yes ___No
If yes, please describe: _____

Does your child use any special equipment (*e.g.*, glasses, hearing aide, splints)? ___Yes ___No
If yes, please 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 the evaluation or services begin, please provide written documentation to include in your child's records.

Is your child ALLERGIC to any medications? ___Yes ___No If yes, what? _____
Please list reactions to allergy along with severity: _____
Is your child ALLERGIC to any foods? ___Yes ___No If yes, what? _____

Please list reactions to allergy along with severity: _____
Is your child on a specific or special diet (*e.g.*, gluten, casein, food coloring, sugar)? ___Yes ___No
If yes, please describe: _____

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 word 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 mark the tasks your child can do independently at this time:

Drinks from:	___Bottle ___Regular cup	___Spouted or special cup ___Blows out candles	___Straw
Feeds self:	___Finger feeds ___Cuts with knife	___Eats with spoon	___Eats with fork
Brushes teeth:	___Tolerates parent	___Attempts to brush, requires assistance	___Brushes independently
Undresses:	___Shirt ___Socks	___Pants ___Shoes	___Underwear
Dresses:	___Shirt ___Socks	___Pants ___Shoes	___Underwear
Shoelaces:	___Ties shoelaces	___Fastens Velcro shoes	
Buttons:	___Opens large PJ buttons ___Opens button on top of pants	___Opens small dress shirt buttons	___Fastens small dress shirt buttons
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
Sleep:	___Sleeps all night ___Needs special routine (*e.g.*, music, light) If yes, please explain routine: _____	___Wakes up frequently	___Sleeps in own bed

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			

ITEM	DESCRIPTION	YES	NO	EXPLANATION
4.	Head banging			
5.	Aggression/destructiveness			
6.	Nervous habits (*e.g.*, nail biting)			
7.	Under or over reactive to sounds			
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 mark any social skill in which your child demonstrates difficulty:

___Initiating/responding to greetings/farewells of peers
___Maintaining the "give and take" of conversations
___Responding to questions during conversation
___Maintaining eye contact during conversation
___Recognizing facial expressions, non-verbal cues, or "body language" of others
___Sustaining activities with peers
___Initiating conversations with peers
___Asking questions during conversation
___Expressing verbally how they are feeling

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 Previous Services below.

Which of the following do you think your child understands?

___Their own name
___Names of objects
___Simple directions
___Conversational speech
___Family names
___Names of body parts
___Complex directions

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

___Looking at objects
___Pointing at objects
___Vocalizing/grunting
___Physical manipulation
___Gestures
___Crying
___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?

___Does not seem aware of speech/communication problem
___Tries to say sounds or words more clearly when asked
___Has been teased about their speech
___Is easily frustrated when not understood

Describe your child's current communication status (*e.g.*, verbal, sign language, communication device):

_____

If your child is not yet using words, do they produce any sounds? ___Yes ___No
If yes, which sounds? _____
Does your child have difficulty producing certain sounds? ___Yes ___No
If yes, which sounds? _____
Does your child stutter when attempting to say a word? ___Yes ___No
Do you have concerns about your child's voice (*e.g.*, too soft, too loud)? ___Yes ___No
What is your reaction to your child's speech? _____

_____

Previous Services:

Has your child previously received services? ___Yes ___No If yes, please list below.

SERVICE	WHO	WHERE	WHEN
Occupational therapy			
Speech-language therapy			
Physical therapy			
Feeding therapy (circle OT or SLP)			

Please state the focus and outcomes of the above therapy: _____

_____

Has your child been evaluated or received therapy here or at any another facility this calendar year?
___Yes ___No (If yes, please speak with the front office regarding transferring the evaluation and/or units.)

Billing Information for Accepted Insurance Carriers:

Sensational Kids, Inc. is currently in-network providers with the following insurance companies: Blue Cross/Blue Shield, Tricare, HealthChoice, OSMA and Medicaid/SoonerCare (Humana, Ambetter (Aetna), Oklahoma Complete Health), United Healthcare, Web TPA, and Cigna. If you are a member of one of these providers, Sensational Kids, Inc. 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 your insurance company is out-of-network, full payment of service is due the day of service. Sensational Kids, Inc. 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: _____ Insurance co. phone: _____
Group #: _____ ID #: _____
Name of sponsor: _____ Employer's name: _____
Sponsor's SSN: _____ Sponsor's DOB: _____
Does policy holder live with patient? ___Yes ___No
If no, please provide address of policy holder: _____

Secondary Insurance Information:

Insurance co. name: _____ Insurance co. phone: _____
Group #: _____ ID #: _____
Name of sponsor: _____ Employer's name: _____
Sponsor's SSN: _____ Sponsor's DOB: _____
Does policy holder live with patient? ___Yes ___No
If no, please provide address of policy holder: _____

Billing Information for Private Pay Therapy:

If Sensational Kids, Inc. is 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 the 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:

- 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 treatment, it is my responsibility to provide written changes to Sensational Kids, Inc. (*e.g.*, 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, Inc. will attempt to reschedule the appointment. In the event that the appointment is not rescheduled, Sensational Kids, inc. 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, Inc. 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, Inc. may then disclose any or all of the patient's information to that party to verify charges. Sensational Kid, Inc. 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 the Initial Evaluation:

As soon as the completed paperwork is received at our office and insurance benefits are verified, Sensational Kids, Inc. 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 printed name: _____

Signature: _____ Date: _____