Date: _____

Padra Smith, MS, OTR/L, SIPT
Pediatric Occupational Therapist
New York, NY & Jersey city, NY
padra@mightymindsandmuscles.com
Office: (917) 960—0250

NEW CLIENT INTAKE FORMS

Please review and complete this form in its entirety. All information provided is confidential.

Child's Name: _____ Date of Birth: _____ Age: ____Y____M

Parents' Name: (1)_____(2)_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Office Phone: _____

Cell Phone 1: _____ Cell Phone 2: _____

Email 1: _____ Email 2: _____

What is your preferred form of communication?
Home Phone ☐ Office Phone ☐ Cell 1 ☐ Cell 2 ☐ Text 1 ☐ Text 2 ☐ Email 1 ☐ Email 2 ☐

Caregiver (nanny, babysitter): _____

Caregiver Cell Phone: _____

How did you hear about us? Search Engine ☐ Sidewalk Sign ☐ Walk-In ☐ New York Special Child Ad ☐

Word of mouth: _____ (source) Other: _____ (explain)

Schooling:

Current school: _____

Current Grade: _____ Current Teacher: _____
Can we contact teacher? YES☐ NO☐ MAYBE ☐ Contact info:_____

LATER Schools attended: _____

Identified as Special Education Student? YES ☐ NO ☐

Check one: Full-time Learning Support ☐ Part-time Inclusion ☐ Full-time Inclusion ☐

If part-time inclusion, note which classes included: _____

Does your child have a *history* with an IEP or IFSP? YES ☐ NO ☐
Does your child have an *active* IEP or IFSP? YES ☐ NO ☐

Please share copy of current IEP/IFSP.

At what age did your child begin kindergarten? _____

Has your child ever been retained in kindergarten or elementary?
YES ☑ NO ☐ EXPLAIN:_____(which grade and reason)

Extracurricular activities: _____
_____

What is the primary language spoken at home? _____
Are any other languages used in the home? _____

Previous evaluations:
CHECK ALL THAT APPLY.
If you say yes to any of the areas below, please provide one copy of the latest report done.

OT:	NO☐YES☐@-	School☐	Hospital ☐	Private Practice☐	Date:_____
PT:	NO☐YES☐@-	School☐	Hospital ☐	Private Practice☐	Date:_____
Speech Therapist:	NO☐YES☐@-	School☐	Hospital ☐	Private Practice☐	Date:_____
PSYCHOLOGIST:	NO☐YES☐@-	School☐	Hospital ☐	Private Practice☐	Date:_____
NEUROPSYCHOLOGIST:	NO☐YES☐@-	School☐	Hospital ☐	Private Practice☐	Date:_____
ENT/Audiologist:	NO☐YES☐@-	School☐	Hospital ☐	Private Practice☐	Date:_____
VISION Doctor:	NO☐YES☐@-	School☐	Hospital ☐	Private Practice☐	Date:_____

Does your child currently receive any of these services?

OT: NO☐YES☐@- School☐ Hospital☐ Private Practice☐ Frequency:_____
Can we contact? YES☐ NO☐MAYBE LATER☐
Therapist_____ Number/Email: _____

PT: NO☐YES☐@- School☐ Hospital☐ Private Practice☐ Frequency:_____
Can we contact? YES☐ NO☐MAYBE LATER☐
Therapist_____ Number/Email: _____

SLP: NO☐YES☐@- School☐ Hospital☐ Private Practice☐ Frequency:_____
Can we contact? YES☐ NO☐MAYBE LATER☐
Therapist_____ Number/Email: _____

PSYCHOLOGIST: NO☐YES☐@- School☐ Hospital☐ Private Practice☐ Frequency:_____
Can we contact? YES☐ NO☐MAYBE LATER☐
Therapist_____ Number/Email: _____

OTHER SERVICES: _____
(Ex: Tutor, Reading Program, Vision Therapy, Nutritionist, Psychiatrist, etc. **SPECIFY ALL PLEASE**.)
NO☐YES☐@- School☐ Hospital☐ Private Practice☐ Frequency:_____
Can we contact? YES☐ NO☐MAYBE LATER☐
Therapist_____ Number/Email: _____
Therapist_____ Number/Email: _____
Therapist_____ Number/Email: _____

M.M.M. Client Intake **Client:** _____ **Date:** _____

Allergies/Medications: If yes please list allergy and treatment:

Food allergies: YES ☐ NO ☐ _____

Diet Restrictions: YES ☐ NO ☐ GLUTEN FREE ☐ DAIRY FREE ☐ SOY FREE ☐ GRAIN FREE ☐
-Other: _____

Medicine allergies: YES ☐ NO ☐ _____

Other Allergies: YES ☐ NO ☐ _____

Can your child consume food or candy treats when in session? YES ☐ NO ☐
Restrictions: _____

Please check AND list all current and past MEDICATION & VITAMINS or SUPPLEMENTS according to dosage, time of day administered, and reason:

FISH OILS ☐ PROBIOTICS ☐ MULTIVITAMIN ☐ VITAMIN D ☐ VITAMIN B ☐ B12 ☐

List all others…

CURRENT:	PAST:
_____	_____
_____	_____
_____	_____

Child's HEALTH History:
Check all that apply, elaborate when needed.

Frequent ear infections ☐
Rashes or skin problems ☐
Meningitis ☐
Headaches ☐
Seizures ☐
Fevers over 103 ☐
Bowel problems
Head injury ☐
Pneumonia ☐
Asthma ☐

Adenoids or Tonsils removed (circle which) ☐
Lead poisoning ☐
Difficulty with eyes or vision ☐
Difficulty with hearing ☐
Heart difficulties ☐
Anemia ☐
Kidney/urinary problems ☐
Hospitalization (list and describe) ☐

Surgery (list and describe) ☐

Other: _____

None of the Above

Additional Comments:

M.M.M. Client Intake **Client: _____** **Date: _____**

FAMILY HISTORY:

Has any member of **your child's immediate or extended family** shown any of the following:

Hyperactive as a child: YES ☐ NO ☐ EXPLAIN:_____
Difficulty learning to read: YES ☐ NO ☐ EXPLAIN:_____
Difficulty with math: YES ☐ NO ☐ EXPLAIN:_____
Difficulty with writing: YES ☐ NO ☐ EXPLAIN:_____
Kept back in school: YES ☐ NO ☐ EXPLAIN:_____
Speech problems: YES ☐ NO ☐ EXPLAIN:_____
Behavior difficulties in childhood: YES ☐ NO ☐ EXPLAIN:_____
In trouble as a teenager: YES ☐ NO ☐ EXPLAIN:_____
Drinking problem or drug abuse: YES ☐ NO ☐ EXPLAIN:_____

Please fully describe any history of mental health problems in the immediate or extended family (specify member, mental health issue, longevity, treatment, etc.)?

_____
_____
_____

Mother/Parent 1's present age: _____
School level completed: _____
General health: _____
Present occupation: _____

Father/Parent 2's present age: _____
School level completed: _____
General health: _____
Present occupation: _____

Siblings (with age and gender):_____

Check ALL that apply:

Child is : Biological ☐ Surrogate ☐ Adopted ☐ Foster ☐

Birth supported by: Pre-conception fertility drugs ☐ IUI ☐ In-Vitro Fertilization ☐ Surrogacy ☐

If adopted, please note from where and when adoption took place, as well as any pertinent adoption information:

_____
_____

If child is not biological, please explain genetic make-up: _____
_____

Parents are: Married ☐ Separated ☐ Divorced ☐ Deceased (mother) ☐ Deceased (father) ☐

Child lives with: Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparents ☐ Other_____

Siblings living in the same house? Yes ☐ No ☐ (List names and ages):_____

If child lives in multiple homes, please explain the schedule and details of the situation: _____
_____

M.M.M. Client Intake **Client: _____** **Date: _____**

CHILD'S DEVELOPMENTAL HISTORY:

Pre-birth:

High Risk Pregnancy? YES ☐ NO ☐ EXPLAIN:_____
Bleeding during any trimesters? YES ☐ NO ☐ EXPLAIN:_____
Toxemia? YES ☐ NO ☐ EXPLAIN:_____
Illness/injury during pregnancy? YES ☐ NO ☐ EXPLAIN:_____
Smoking during pregnancy? YES ☐ NO ☐ EXPLAIN:_____
Alcohol intake? YES ☐ NO ☐ EXPLAIN:_____
High stress level during pregnancy? YES ☐ NO ☐ EXPLAIN:_____

Mother's age at birth: _____ How many hours did the water break before delivery? _____
Mother's weight gain during pregnancy: _____ lbs. Length of labor? _____
Number of previous miscarriages: ____

Birth/Infancy:

High Risk Birth? YES ☐ NO ☐ EXPLAIN:_____
Premature? YES ☐ NO ☐ EXPLAIN:_____
Gestational age at birth? _____
Birth weight? YES ☐ NO ☐ EXPLAIN:_____
C-section or vaginal birth? EXPLAIN: _____
Medications used during birth process: _____
Required forceps? YES ☐ NO ☐ EXPLAIN:_____
Born with cord around neck? YES ☐ NO ☐ EXPLAIN:_____
Transverse? YES ☐ NO ☐ EXPLAIN:_____
Was a twin or triplet? YES ☐ NO ☐ EXPLAIN:_____
Needed oxygen? YES ☐ NO ☐ EXPLAIN:_____
Difficulty sucking? YES ☐ NO ☐ EXPLAIN:_____
Feeding problems? YES ☐ NO ☐ EXPLAIN:_____
Born with a heart defect? YES ☐ NO ☐ EXPLAIN:_____
Born with or acquired torticollis? YES ☐ NO ☐ EXPLAIN:_____
Born with other complications? YES ☐ NO ☐ EXPLAIN:_____
Has had a: (Circle all that apply) x-ray CAT MRI EXPLAIN:_____
Hospitalized more than 7 days after birth? YES ☐ NO ☐ EXPLAIN:_____
Patient in NICU? YES ☐ NO ☐ EXPLAIN:_____
Is/Was child breast-fed? YES if yes until what age: _____
NO if no, what substitute was used?_____

EARLY CHILDHOOD:

Does your child have…
Shyness with strangers? YES ☐ NO ☐ EXPLAIN:_____
Difficulty keeping on a schedule? YES ☐ NO ☐ EXPLAIN:_____
Difficulty with routine changes? YES ☐ NO ☐ EXPLAIN:_____
Extreme restlessness? YES ☐ NO ☐ EXPLAIN:_____

M.M.M. Client Intake **Client: _____** **Date: _____**

Overexcites easily?	YES ☐ NO ☐	EXPLAIN:_____
Seeks being held?	YES ☐ NO ☐	EXPLAIN:_____
Overacts to sights/sounds?	YES ☐ NO ☐	EXPLAIN:_____
Underreacts to sights/sounds?	YES ☐ NO ☐	EXPLAIN:_____
Temper tantrums?	YES ☐ NO ☐	EXPLAIN:_____
Resistance to hugs/touching?	YES ☐ NO ☐	EXPLAIN:_____
Irritability?	YES ☐ NO ☐	EXPLAIN:_____
Cries often and easily?	YES ☐ NO ☐	EXPLAIN:_____
Self-destructive behavior?	YES ☐ NO ☐	EXPLAIN:_____
Self-stimulatory behavior?	YES ☐ NO ☐	EXPLAIN:_____
Poor eye contact?	YES ☐ NO ☐	EXPLAIN:_____
Not affectionate?	YES ☐ NO ☐	EXPLAIN:_____
Jerking of arms/head?	YES ☐ NO ☐	EXPLAIN:_____
Feeding difficulty?	YES ☐ NO ☐	EXPLAIN:_____
Colic?	YES ☐ NO ☐	EXPLAIN:_____
Constipation?	YES ☐ NO ☐	EXPLAIN:_____
Trouble falling/staying asleep?	YES ☐ NO ☐	EXPLAIN:_____
Stiffness or rigidity	YES ☐ NO ☐	EXPLAIN:_____
Looseness or floppiness?	YES ☐ NO ☐	EXPLAIN:_____
Difficulty riding 2 wheel bike?	YES ☐ NO ☐	AGE LEARNED:_____

Infant/early childhood development

Check the age at which the milestone was reached.

Sat up without help	4-6 mo. ☐	7-9 mo. ☐	10-12 mo. ☐	13-15 mo. ☐	16-18 mo. ☐	>19 mo. ☐
Crawled	4-6 mo. ☐	7-9 mo. ☐	10-12 mo. ☐	13-15 mo. ☐	_____ mo ☐	SKIPPED ☐
Walked alone, 10 steps	10-12 mo. ☐	12-14 mo. ☐	15-20 mo. ☐	21-24 mo. ☐	2-3 yr. ☐	>3 yr. ☐
Walked up stairs	12-24 mo. ☐	2-3 yr. ☐	3-4 yr. ☐	4-5 yr. ☐	5-7 yr. ☐	>7 yr. ☐
Rode a tricycle	12-24 mo. ☐	2-3 yr. ☐	3-4 yr. ☐	4-5 yr. ☐	5-7 yr. ☐	>7 yr. ☐
Caught a big ball	12-24 mo. ☐	2-3 yr. ☐	3-4 yr. ☐	4-5 yr. ☐	5-7 yr. ☐	>7 yr. ☐
Spoke first words	6-12 mo. ☐	12-24 mo. ☐	2-3 yr. ☐	3-4 yr. ☐	4-5 yr. ☐	>5 yr. ☐
Put words together	6-12 mo. ☐	12-24 mo. ☐	2-3 yr. ☐	3-4 yr. ☐	4-5 yr. ☐	>5 yr. ☐
Spoke 2-3 word sentences	12-24 mo. ☐	2-3 yr. ☐	3-4 yr. ☐	4-5 yr. ☐	5-7 yr. ☐	>7 yr. ☐
Understood by strangers	12-24 mo. ☐	2-3 yr. ☐	3-4 yr. ☐	4-5 yr. ☐	5-7 yr. ☐	>7 yr. ☐

At what age was your child toilet trained? _____

Are there any current issues with toilet training?

YES NO EXPLAIN:_____

Has your child endured any extremely stressful experiences? Please explain: _____

_____

_____

M.M.M. Client Intake **Client: _____** **Date: _____**

Primary Reason for Referral:

If you are here for TOMATIS METHOD LISTENING PROGRAM or CELLFIELD READING INTERVENTION please describe why think one of these programs suits your child's needs.

I am NOT familiar with these programs. ☐

Please provide me with more information about TOMATIS – CELLFIELD ☐

Other Comment/Concerns:

Scheduling limitations (for regularly scheduled therapy sessions, if needed):
Please explain school hours, unchangeable after-school commitments, etc.

Based on our previously discussed fee schedule, please note which level evaluation would like and whether you would like a SUMMARY with verbal feedback or a FULL narrative report (cost difference is noted on the fee schedule). Ask for an additional copy, if needed.

ALL evaluations come with a parent feedback meeting (both parents are required to be present.)

CHECK ONE:

☐	**BASIC Evaluation** – Summary ONLY	☐	**BASIC Evaluation** – W/ Narrative Report
☐	**STANDARD Evaluation** – Summary ONLY	☐	**STANDARD Evaluation** – W/ Narrative Report
☐	**COMPREHENSIVE Evaluation** – Summary ONLY	☐	**COMPREHENSIVE Evaluation** – W/ Narrative Report
☐	***TOMATIS METHOD* Listening Test & Evaluation**	☐	***CELLFIELD* READING INTERVENTION Reading and Visual Tests**

HIPAA RELEASE FORM

(Required by law. – Notice of your rights regarding documents.)

AUTHORIZATION FORM

I, _____hereby authorize Mighty Minds and Muscles, Padra Smith, MS, OTR/L (DBA: Mighty Minds and Muscles) and its affiliates, its employees and agents to *release* to students, therapists and other professionals at or associated with Mighty Minds and Muscles Therapy and Coaching Services my or my child's personal health information maintained by Mighty Minds and Muscles Therapy and Coaching Services (e.g., information relating to the diagnosis, treatment, claims payment, assignment of benefits, and health care services provided or to be provided and which identifies my name, address, social security number) **except** the following information about me/my child:
_____ [DESCRIBE INFORMATION **NOT** TO BE DISCLOSED, **IF ANY**] for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire at the end of my child's therapeutic program and invoicing at Mighty Minds and Muscles or the date of my choosing: _____ .**(Initial)**

I understand that I have a right to revoke this authorization by providing written notice to Padra Smith, MS, OTR/L (DBA: Mighty Minds and Muscles). However, this authorization may not be revoked if Mighty Minds and Muscles, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Child: _____Date: _____

If applicable, Legal Representatives sign below: By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Guardian/Representation: _____

Signature of Legal Guardian/Representative: _____Date: _____

Name of Witness: _____ (Witness can be M.M.M. staff, as needed.)

Signature of Witness:_____ Date: _____

INSURANCE INFORMATION

It is recommended that all participants be covered under a health insurance policy while attending a therapeutic program. (Although we do not seek coverage/reimbursement.)

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD FOR OUR RECORDS

Do you plan to seek reimbursement from your insurance company? YES ☐ NO ☐ MAYBE ☐

Please note: We are out-of-network and require payment at the time of service (or billing). You must submit claims on your own. All invoices will contain necessary codes and license numbers.

PRIOR-APPROVAL: Some insurance companies require a PRIOR-APPROVAL for O.T. evaluations or services. This requirement is often needed 5 days before the evaluation. Please call your insurance company and note your company's policies.

Does your insurance company require a prior-authorization? YES ☐ NO ☐ N/A ☐

Health Insurance Company: _____ Plan: _____ Phone: _____
Insured Member: _____ Group Number: _____Member Number: _____

Insured DOB: _____ Insured SS#: _____ Insured Employer:_____

Benefit details (If possible, please note your 'out-of'network' benefit details):

Visits per year: _____ Deductible: _____ Co-Payment: _____ Co-Insurance:_____

% of 'Reasonable & Customary' fee reimbursement rate: _____ Filing deadline: _____

PRESCRIPTION: *Each participant MUST also have a **current Occupational Therapy prescription** on file in order to participate in O.T. interventions (due to NY/NJ State Licensure Standards and Regulations). The prescription is not required for the evaluation phase.

Child's Pediatrician: _____ Phone: _____ Fax:_____

Pediatrician's address: _____ City: _____ State:_____ Zip:_____

Pediatrician's License number: _____ Pediatrician's EIN number: _____

Please note, that some pediatricians appreciate a summary of our evaluation results and we may send this document to the above-mentioned doctor.

May we contact your pediatrician? YES ☐ NO ☐ MAYBE LATER ☐

CHILD's EMERGENCY CONTACT (Not parents.)

Primary Person to Contact in Case of Emergency: _____

Relationship: _____Emergency Phone #: _____

PARENT AUTHORIZATION AND GENERAL RELEASE FROM LIABILITY

For all programs/services offered by Mighty Minds and Muscles/Padra Smith MS, OTR/L and associated agents.

I, _____(parent), am signing for myself or on behalf of my child_____, and I understand and agree that the terms below are contractual. My intent in signing this document is to acknowledge and assume the risks involved in allowing my child to participate in programs/services provided by Mighty Minds and Muscles. I understand the risks involved and release Padra Smith, MS, OTR/L (DBA: Mighty Minds and Muscles) and its Agents and **Assigns, from any liability not caused by their direct and willful negligence with respect to my and my child's involvement, injury or death in this program/services**.

Initial: _____

I approve of my child's attendance in this program and certify that s/he is in ***good health and is fit to participate***. I understand that there are inherent risks and strenuous physical activities in this program, which have been considered and which the participant assumes. Initial_____

Participant has medical insurance. I agree to hold harmless Padra Smith, MS, OTR/L (DBA: Mighty Minds and Muscles) and agents and assigns from claims or **damages due to injury to person or property** arising from my child's participation in this program.

Initial:_____

I consent to ***emergency treatment*** for my child, if in the judgment of Padra Smith, MS, OTR/L (DBA: Mighty Minds and Muscles) and Agents and Assigns and it is required. I give Padra Smith, MS, OTR/L and/or Agents permission to call 911 or to take my child to a hospital, emergency room, or doctor to obtain medical treatment if necessary.

Initial: _____

I grant permission for my child to be ***photographed, videotaped or otherwise recorded*** during therapy sessions for **therapeutic purposes** (kept privately to track progress internally).

Initial: _____

I grant permission for my child to be ***photographed, videotaped or otherwise recorded*** and for any such photographs to be **displayed** by Padra Smith, MS, OTR/L (DBA: Mighty Minds and Muscles) in the following forms within reason and prior notice.

Newsletter:	YES ☐	NO ☐
Website:	YES ☐	NO ☐
Educational Presentations:	YES ☐	NO ☐
Marketing Materials:	YES ☐	NO ☐

Initial: _____

THIS WAIVER HAS BEEN READ AND UNDERSTOOD AND IS SIGNED VOLUNTARILY BY ME AS THE LEGAL REPRESENTATIVE FOR THE PARTICIPANT.

Parent's Name (Printed): _____

Parent's Signature: _____ Date: _____

PAYMENT AGREEMENT

I agree to pay for services up front and *may or may not* seek reimbursement afterward from the insurance company.. We **DO NOT** directly bill insurance companies. Submitting claims is patient family's responsibility. Regardless, please provide us with a copy of your child's insurance card for our files. This information is necessary in case Mighty Minds and Muscles needs to communicate with an insurance company on your behalf. Necessary invoices, sessions notes, and reports will be supplied *upon request.*

Please be aware that some insurance companies require a Pre-Authorization/Prior-Approval for OT Evaluations. Some companies may also limit the number of visits covered per year. You may also have a claim submission deadline. *Please call your insurance company to verify. (Insurance information recorded on a separate page).*

Initial: _____

PRESCRIPTION POLICY

I have or will obtain a prescription for "Occupational Therapy Services as needed" (or OT 2x/week, etc.) from my child's pediatrician **PRIOR to commencing therapeutic sessions**. As long as your child is receiving therapeutic services at MMM, a current prescription will be needed yearly.

Initial: _____

CANCELLATION POLICY

If my child misses a scheduled therapy session without canceling at least **24 hours in advance** (with the exception of emergency situations). I agree to pay a cancelation fee that **equals 50%** of the therapy session. Initial: _____

CREDIT CARD INFORMATION

I am willing and able to provide active credit card information to have on file at Mighty Minds and Muscles that will be used ONLY in the case of lack of payments for overdue invoices, to ensure all balances for therapeutic services will be covered. *(Credit card information recorded on another page).*

Initial: _____

I am in agreement will all statements above and will provide any necessary documentation and payments that arise throughout the course of services at Mighty Minds and Muscles.

I have read and reviewed all terms of this contract and agree with all the terms of this contract:

Parent's Name (Printed): _____

Parent's Signature: _____ Date: _____