Ph: (206) 858-0226
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2400 NW 80th St. PMB 102, Seattle, WA 98117

Birth- 12 month intake:

Child's Name: ____ (circle one) Male/Female

Date of Birth: ____________________________ Due date (if different than DOB)_______________

Parent/Caregiver Names: ____

Home Address: ____

City: _____________________________________ State: _____________ Zip: _______________

Home Phone: _______________________________ Cell: ______________________________

Email address: ____

Native Language(s) spoken in the home: ____

Emergency contact name and phone number: ____

Who referred you to Pacific Pediatric Therapy?____

Who is your child's Pediatrician /Family Doctor? ____

Address: __________________________ Phone: ____________________ Fax: ________________

Reason for visit:
Briefly state the reason you are seeking evaluation for your child needs an evaluation
____-
____

When were the problems first identified? ______________________ By whom? ____________________

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 he/she can't do now?)
____
____

Family Information:

Parent/Caregiver: ____ Date of birth:_________________

Occupation: _____________________________ Highest Educational Level: _________________________

Relationship to child: (please circle): Biological Adoptive Step Foster Other

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: ____

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

Is there anything about your religious beliefs we should know that may impact therapy?
____

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

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? ______________________

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, COVID, croup, measles, mumps, meningitis etc.)			
13	Hospitalization/surgery			

Does your child see any specialists (ex. neurology, gastroenterology, pulmonology, CST, etc)
____

Has your child had any difficulties with feeding? (ex. sucking, swallowing, drooling, chewing, reflux, vomiting, choking, weight gain)? Yes___ No___ If yes,
describe:____
____

Does your child have difficulty with sleeping?
Yes___ No___ If yes, describe: ____

Do you have concerns about developmental delays?
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 for daily activities? Yes___ No___
(ex. glasses, hearing aide, splints, wheelchair, etc.)
If yes, please list: ____

Developmental History:

Please indicate the age when your child first performed each of the following INDEPENDENTLY. (It is okay to list an approximate age.) Please mark whether you believe your child accomplished the milestone Early, On Time, or Late. If your child has not yet achieved the milestone, write NA in the age column.

MILESTONE	EARLY	ON TIME	LATE	IF LATE, AT WHAT AGE?
Said first words / named single objects				
Used simple questions (ex., where's mom?)				
Followed simple 1 step directions				
Said 2-3 phrases				
Lifted head when on tummy				
Rolled Over				
Sat unsupported				
Crawled on hands and knees				
Stood Alone				
Walked by self				

Other: Is there anything that was not asked in the form that you feel is important for your therapist to know prior to initial visit and assessment?

____

____

Billing Information for Private Pay Occupational Therapy:

At this time Pacific Pediatric Therapy is a private pay for service company. Initial in home Evaluation Fee is $250.00 for 60-90 minute session. Follow up Occupational therapy treatment sessions are $120.00 for one hour sessions. Families are welcome to request a Superbill (receipt with treatment codes) that you can personally submit to your insurance for reimbursent. All payments are due within 14 days of the time of service(s). Payments can be made via cash, check, or Venmo payment.

Financial Responsibility:

Individual who is financially responsible for this account:

Name: ____

Name of insurance provider: ____

Date: ____________________________

- By signing this form I declare that I am the legal guardian of this minor and allowed by law to make decisions for testing/assessment of 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 Pacific Pediatric Therapy. (ex. new insurance information, home address, phone number, etc.).

- I understand I am financially responsible for services rendered by Pacific Pediatric Therapy 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 Pacific Pediatric Therapy .

- I agree to be personally responsible for evaluation and or treatment charges. In the event 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, we ask for at least 48 hours notice when able. If attendance becomes an issue with an excessive amount of cancellations, then your child could be in jeopardy of being removed from our schedule.

Release of Information:

Pacific Pediatric Therapy office may disclose any or all of the patient's information for insurance claim purposes. If another party is paying the patient's bill, Pacific Pediatric Therapy may then disclose any or all of the patient's information to that party to verify charges. Pacific Pediatric Therapy's office 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 via email, a member of the team will contact you to schedule an evaluation. If you have not received a call within one week of returning the paperwork, please contact us. We look forward to being part of your team!

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

Parent/Caregiver
(Please Print Name): ____

Signature: _______________________________________ Date: ________________________