Journeys
Occupational Therapy

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PEDIATRIC INFORMATION FORM

Name:	**DOB:**		**Today's Date:**
Parent/Guardian Name:			
Address:	City/State:		ZIP:
Phone (H):	(W):	(C):	
Email:		Occupation:	
Other Parent/Guardian Name:			
Contact info if different than above: Address:	City/State:		ZIP:
Phone (H):	(W):	(C):	
Email:		Occupation:	
Emergency Contact:		**Phone:**	
Age(s) and sex(es) of siblings:			
Who referred you to us?		May we thank them? Yes	Please don't
Primary Physician:		**Practice Name/Location:**	
Does your child have a medical diagnosis?			
Any other relevant physicians or practitioners:			
Name of school child attends (if applicable)			Grade:
What are your child's strengths?			
What is your primary reason for this appointment?			
Has your child received Occupational Therapy before? If so, for what concerns, and how long?			
Is your child receiving any other intervention/treatment? If so, what?			
Is there any recent crisis or current stressor that is affecting your child at this time?			

BACKGROUND INFORMATION

Prenatal & Birth History (if known)	Please circle and describe
Complications, illness/infection/stress during pregnancy?	YES / NO Describe:
Complications during labor and delivery?	YES / NO Describe:
Forceps / Vacuum / C-section?	Please elaborate:
Birth order	Birth weight
How many weeks gestation at delivery?	
Breast fed?	YES / NO How long? Strong suck? YES / NO Spit up frequently? YES / NO
Any feeding challenges?	
History of: (check any that apply)	____ Tethered oral tissues ____ Torticollis ____ Brachiocephaly ____ Plagiocephaly
Problems with respiration?	
Problems sleeping?	
Irritable / Happy / Quiet baby?	
Does/did baby enjoy tummy time play?	YES / NO

Developmental Milestones – please write approximate age achieved:		
Rolled over:	Crawled on hands and knees:	
Sat:	Cruised along furniture:	Said first words:
Belly crawled:	Walked:	Talked:

MEDICAL HISTORY (Please add pertinent details)

Ear infections: YES / NO How many and at what ages?
Allergies: YES / NO Specify:
Seizures: YES / NO Describe:
Injuries: YES / NO Describe:
Hospitalizations: YES / NO Elaborate:
Wears glasses: YES / NO For what reason?
Has your child had corrective surgery for strabismus or eye motor difficulties? YES / NO
Medications: YES / NO (please list and include OTC)

Any other pertinent medical information, including precautions or allergies that the therapist should be aware of, especially contraindications for active movement, or hydrocephaly?

CONSENT FOR CARE

You have the right to seek a second opinion or to end the evaluation/treatment at any time. You are entitled to information about the methods and techniques used in the evaluation/treatment. You may also ask the therapist for information about their training and credentials.

I, _____, understand that Occupational Therapy and/or Craniosacral Therapy is not a substitute for standard medical care. I will alert the practitioner to any changes in my child's health status, including medication changes. It is my choice to receive Occupational Therapy and/or Craniosacral Therapy for my child with an understanding of the risks and benefits, and I give my consent for treatment of my minor child. I understand that sensory gym based pediatric occupational therapy involves some physical risk taking and may result in minor bumps and falls at times. I also understand that there is no stated guarantee for effectiveness of treatment.

Signature_____Date_____

PAYMENT POLICY

Full payment is due at the time of service, unless other arrangements have been made in advance. Comprehensive evaluation rate is $480, and includes standardized or nonstandardized testing as appropriate, observations, interviews/phone conversations, and written report. On prior agreement for private pay only services (not submitting to insurance) a brief eval without a report can be completed for $300. Treatment rate is $120 for a 50 minute session. Late arrivals cannot be guaranteed an extension of scheduled treatment time, and will be responsible for full fee. We are not in network with any insurance companies; we can submit as an out of network provider on your behalf if receiving medically-based Occupational Therapy services with an MD script for OT services. Itemized invoices can be provided at the end of the month for your health card account.

Cancellations: Please make any cancellations or schedule changes 24-48 hours in advance when at all possible (exceptions for illness and weather-related events); **cancellations within 24 hours or no-shows will be subject to a $50 cancellation fee at therapists' discretion.**

Please initial indicating understanding of payment & cancellation policies:_____