SawdustOT@gmail.com

Front of File Form

Child Name:_____

Date of Birth _____ Age_____

Home/Cell Phone Number_____

Parents Name_____

Address_____

Email_____

Caregivers name (if any)_____

Caregivers phone number_____

Emergency Contact_____

Phone number_____

Please list any emergent health concerns such as seizures:

_____

_____

_____ _____

Parents Signature Date

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----------Insurance Information----------

Medical Insurance Provider_____

Medical Reference/Record Number_____

Group Number_____

Subscriber Name_____

----------Referring Information----------

Who referred the child/young adult for evaluation?_____

Reason for referral? _____

What is the primary concern/goal for therapy?

_____

_____

_____

What are your child's/young adult's strengths?

_____

_____

_____

----------School Information----------

Currently in School: Y/N Highest Grade Achieved:_____

School Name and Teacher:_____

Hand Preference (circle one): Right Left Both

Has your child/young adult ever received special instruction or have an established IEP? Y/N

Has your child/young adult ever received school based therapy? OT PT Speech

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----------Medical Information----------

Current prescribed medications?_____

Known food allergies?_____

Medical Precautions?_____

Diagnosis provided by physician?_____

Frequent hospitalizations? Yes No Length of Stay?_____

Surgeries?_____

Currently receiving services from other healthcare professionals? (circle all that apply)

Psychologist PT Speech and Language Nutritionist Behavioral Specialist

----------Developmental Milestones----------

Developmental milestones were met: ☐Within typical age ranges ☐delayed

If delayed please specify to the best of your ability:

_____

_____

_____

Please check the amount of assistance needed for your child/young adult to complete the following:

Self Care:	Independent (completes without help)	I assist 50% or more	Dependent (total assistance needed)
Takes off pants			
Puts on pants			
Takes of shirt			
Buttons			
Zipper			
Put on shoes			

Take off shoes			
Ties shoes			
Puts on socks			
Takes off socks			
Toileting			

Describe your child/young adult at present:

	Yes	No	Sometimes
Mostly Quiet			
Overly Active			
Tires Easily			
Talks Constantly			
Too Impulsive			
Restless			
Resistant to Change			
Fights Frequently			
Usually Happy			
Exhibits Temper tantrums			
Nervous Ticks/Habits			
Poor Attention			
Frustrated Easily			
Sluggish in mornings			
Unusual Fears (list)			

----------Social and Occupational history----------

Does your child/young adult:

	Often	Sometimes	Rarely
Socialize with family and close friends?			
Communicate needs and wants effectively?			
Hard to make friends?			
Tend to interact/play with younger			

children?			
Enjoy time alone?			
Tolerate change in routine?			

In the community, does your child/young adult:

	Often	Sometimes	Rarely
Tolerate running errands?			
Enjoy eating in restaurants?			
Attending birthday parties?			
Attending family gatherings?			

----------Sensory Processing Checklist----------

This is not to be used as diagnostic criteria for labeling children with sensory processing disorder. This is to assist both the parents and therapist with the ability to become educated about your child/young adults sensory processing needs. Please check symptoms that you feel best describe your child's/young adults sensory behaviors.

Signs of Tactile Dysfunction

Hypersensitivity to touch (Tactile Defensiveness)

	Becomes Fearful of, anxious or aggressive with light or unexpected touch
	Appears fearful of avoids standing in close proximity to other people or peers
	Complains about having hair brushed; particular about using a specific comb
	Avoid group situations for fear of unexpected touch
	Resist friendly or affectionate touch from anyone besides parents/siblings
	Prefers hugs
	Dislikes kisses, will "wipe off" placed where kissed
	May overreact to minor cuts, scrapes and/or bug bites
	Avoids touching certain textures of material (blankets, rugs, stuffed animals)
	Refuses to wear new or stiff clothes, clothes with rough textures,

	Avoids using hands for play
	Avoids/dislikes/averse to "messy play" (sand, mud, water, glue, glitter, slime, shaving cream)
	Distressed by clothes rubbing on skin- prefers shorts and short sleeve shirts year round
	May want to wear long sleeve shirts and pants year round to avoid having skin exposed
	Distressed about tags in clothing
	Distressed about having face washed
	Distressed about having hair, toenails, fingernails cut
	Resists brushing teeth
	May refuse to walk barefoot on grass/sand
	May walk on toes only

Hyposensitivity to movement (under-responsive)

	May crave touch, needs to touch everything and everyone
	Not aware of being touched/bumped unless done with extreme force
	Not bothered by injuries (cuts, bruises), shows no distress with shots
	May not be aware that hands or face are dirty or feel a runny nose
	May be self-abusive' pinching, biting, banging head against objects
	Mouths objects excessively
	Frequently hurts other children or pets while playing
	Repeatedly touches surfaces or objects that are soothing
	Craves vibrating or strong sensory input
	Thoroughly enjoys and seeks out messy play

Signs of Vestibular Dysfunction

Hypersensitivity to Movement (over-responsive)

	Prefers sedentary tasks, moves slowly and cautiously, avoids taking risks
	May appear terrified of falling even when there is no real risk of it
	Afraid of heights, even the height of curb/step
	Fearful of going up/down steps or walking on uneven surfaces
	Loses balance easily or may appear clumsy
	Avoids rapid or rotating movements

Hyposensitivity to movement (under-responsive)

	In constant motion, can't seem to sit still
	Craves fast, spinning, and/or intense movement experiences

	Loved being tossed in air loves fast, intense, and/or scary rides at amusement parks
	Thrill seeker
	Rocks body, shakes leg, or head while sitting

Sensory seeking Behaviors

	Seeks out jumping, bumping and crashing activities
	Stops feet when walking
	Prefers clothes as tight as possible
	Loves "rough housing" and tackling/wrestling
	Freqeuntly falls on floor intentionally
	Loves pushing, pulling, dragging objects
	Chews on pens, straws, shirt sleeves
	Grinds teeth throughout day

Signs of Auditory Dysfunction

Hypersensitivity to sounds

	Distracted by sounds not normally not normally noticed by others (fans, heaters, humming lights)
	Fearful of the sound of flushing toilet, vacuum, hairdryer, squeaky shoes, dog barking
	Startled or distracted by loud or unexpected sounds
	Bothered/distracted by background environmental sounds
	Runs away, cries/covers ears with loud or unexpected sounds

Hyposensitivity to sounds

	Often does not respond to verbal cues or to name being called
	Appears to make noises for noise sake
	Loves excessively loud TV or music
	Appears oblivious to certain sounds
	Appears confused about where sound is coming from
	Talks self through a task often out loud
	Needs directions repeated often, or will say, "what" frequently

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Emotional Response, play and self-regulation dysfunction

	Difficulty accepting changes in routine (to point of tantrums)
	Gets easily frustrated
	Ofeten inpulsiv
	Functions best in small group or individuals
	Variable and quickly changing moods; prone to outbursts and tantrums
	Prefers to play outside, away form groups, or just be an observer
	Avoids eye contact

Please provide any additional information that will help to better understand your child:

_____
_____
_____
_____
_____
_____

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Authorization for Treatment

_____(initial) I hereby authorize Sawdust Occupational Therapy to provides Occupational therapy treatment and services to myself or below names patients. I also authorize the release of such information that may be necessary for care via mail, email or fax.

_____(initial) I understand that I have certain right to privacy regarding my protected health information regarding my protected health information. These rights are given to me under the health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by singing this consent I authorize Sawdust Occupational Therapy to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payors (insurance companies)
- The da-to-day healthcare operations of Sawdust Occupational Therapy

_____(initial) I understand that I have the right to requested restrictions on how my protected health information is used on disclosed to carry out treatment, payment and health care operations but that Sawdust Occupational Therapy IS not required to agree to these requested restrictions. However, if Sawdust Occupational Therapy does agree, Sawdust Occupational Therapy is then bound to comply with this restriction.

_____(initial) I understand that I may revoke the consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke the consent is not affected.

_____(initial) I understand that complete Privacy Policy is available to me at any time

_____Signature of patient or Responsible Party

_____Date

_____Patient Name _____Relationship to patient

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Termination of Therapy

If you terminate therapy, for any reason, we require **at least 2 weeks of session's prior written notice** in order for the therapist to transition the child/young adult out of therapy and complete closure. We reserve the right to terminate our relationship with a client at any time for any reason. Unless circumstances require otherwise, if we terminate the relationship we will provide at least 2 sessions' prior notice.

Payment/Late Fees

Invoices will be sent via email at the end of each month to be received by the 7th of each month. Invoices are due upon receipt. **Late fees are applied if payment is not received by the 15th of the month.** Collection of past due accounts will be initiated if non-payment of accounts extends beyond 60 days. A credit card will be held on file and used in the event of a 30 day past due invoice. You will be responsible for payment of reasonable attorney fees and all collection costs, including court costs in the event action is commenced to collect past due accounts. Collection agency fees shall be no less than 35% of the outstanding balance. **If invoice payments are received late 2 months in a row, Sawdust Occupational Therapy has the right to request pre-paid month invoices for services. Payment for upcoming months of services must be received before the 5th of each month.**

Change in Policies

The terms and conditions in this pooicy may change from time to time. Such changes will occur and every effort will be made to provide a 30 day written notice.

Authorization

I agree to the above policies/practices for my child/young adult and/or self _____

Signature _____

Full Name_____

Date_____

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Insurance

Practices and Policies

Cancellations and Attendance Policies

To cancel an upcoming appointment, you must call or email your therapist within 24 hours of your coming scheduled appointment. Failure to do so will result in a $35 cancellation fee.

A: Attendance Policies for Excused Absences

1. We require 24 hour notification for cancellation due to illness
2. Two week notification is required for any non-illness absence.

B. Violation of Attendance policies

1. If a child has 2 or more excused absences within a one-month period, our child may lose their scheduled appointment time.

2. Unexcused absences (less than 24 hour notice) may result in a cancellation fee of $35.

3. If a parent/guardian or other approved caregiver is 10 or more minutes late for pick-up without prior coordination with therapist, your child may lose their future scheduled appointment times

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_____Signature of patient or Responsible Party

_____Date

_____Patient Name _____Relationship to patient

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Authorization for Credit Card Use

ALL Clients

All information will remain confidential

Name on Card: _____

Billing Address: _____

_____

(city, state, zip)

Credit card type: Visa MasterCard Discover Amex

Credit Card Number: _____

Expiration Date: _____

Identification Number: _____ (last three or four digits on back of card)

Authorization: I Authoritze Sawdust Occupational Therapy LLC. To charge this credit card for late payments on invoices due and payments associated with any documentation, report writing and or consultation which have not been paid in due time according to the practices and policies.

Signature: _____

Print Name: _____

Date: _____

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PHOTO RELEASE FORM

I hereby grant permission to *SawDust Occupational Therapy LLC* to use photographs, video and other media of _____ in publications, news releases, online, and in other communications related to the mission of *SawDust Occupational Therapy LLC.*

_____

(Signature of Adult, or Guardian of Children under age 18)

Name _____

Address _____

_____

Phone (day)_____(evening)_____

Email Address (optional) _____