Keiki Therapy-Occupational/Physical Therapy Intake Form (Child)

phone 808-209-7934
fax 808-883-6262
intake@keikitherapy.com

Keiki Therapy

Client Information

First name *

Last name *

Date of birth *

Preferred pronoun

Example: he/him/his, she/her/hers, they/them/theirs

Primary Parent or Guardian Information

First name *

Last name *

Primary phone number *

Secondary phone number

Mailing Address *

Physical Address *

City *

State *

Zip *

Email address *

Parent or guardian date of birth *

Relationship to child *

Secondary Parent or Guardian Information

First name *

Last name *

Primary phone number *

Secondary phone number

Mailing Address *

Physical Address *

City *

State *

Zip *

Email address *

Parent or guardian date of birth *

Relationship to child *

Is your child adopted?

- Yes
- No

If your child is adopted, does he/she know?

- Yes
- No

Insurance Information

Do you have medical insurance?

- ○ Yes
- ○ No
- ○ I prefer to pay completely out of pocket.

Keiki Therapy will bill your insurance for services unless you request otherwise. If you have private insurance it is possible that you may have a deductible, co-pay, or coinsurance for each therapy session. If insurance does not cover services you will be responsible for payment.

☐ Agree *

Change of Insurance I agree to notify Keiki Therapy, LLC. within 5 business days of any change of insurance. Change of insurance does not guarantee coverage of therapy services and failure to provide accurate insurance information in a timely manner will result in the unpaid insurance balance being transferred to patient responsibility.

☐ Agree *

Primary Health Insurance Provider *

Primary Health Insurance Subscriber ID *

Primary Health Insurance Subscriber's Name *

Primary Health Insurance Subscriber's Date of Birth *

Primary Health Insurance Provider Phone Number and/or Contact Number

(found on the back of insurance card)

Secondary Health Insurance Provider

Secondary Health Insurance Subscriber ID

Secondary Health Insurance Subscriber's Name

Secondary Health Insurance Subscriber's Date of Birth

Secondary Health Insurance Provider Phone Number and/or Contact Number

(found on the back of insurance card)

Medical History

Was your child born:

- [ ] Full Term
- [ ] Premature

Was your child born:

- [ ] Vaginal
- [ ] Cesarean

Any complications during pregnancy:

Any complications at birth? If premature, how many weeks?

Any previous hospitalizations or surgeries? *

- ( ) Yes
- ( ) No

If Yes, explain

Has your child ever had a seizure? *

- ◯ Yes
- ◯ No

If Yes, how often and date of last seizure

Has your child had a formal eye exam by an Optometrist? *

- ◯ Yes
- ◯ No

Date of last vision exam

Does your child wear glasses? *

- ◯ Yes
- ◯ No

Has your child ever been formally diagnosed with anything? If so, what and by whom? *

Does your child have adaptive equipment?

List medications currently taking

List allergies

List food hypersensitivities

Services

Has your child seen any of the following specialists?

- [ ] Audiologist
- [ ] Speech Therapist
- [ ] Occupational Therapist
- [ ] Neurologist
- [ ] Physical Therapist

Please list the MD's / specialists that are following your child including frequency of visits:

School attending and grade level

Does your child have an Individualized Education Program (IEP) or 504 Plan with school system?

- ( ) Yes
- ( ) No

If Yes, describe the services that they receive

Any concerns regarding fine motor skills? Examples: grasp, handwriting, using utensils

Any concerns regarding gross motor skills? Examples: walking, riding a bike, jumping

Any concerns regarding self-care? Examples: dressing, brushing teeth, bathing

Any concerns regarding feeding? Examples: picky eater, gagging, swallowing difficulties.

Any concerns regarding sensory processing? Example: getting messy, loud noises, spinning, rocking

Any concerns regarding language/social skills? Example: following directions, playing with others

Any problems with behavior or attention? Example: tantrums, sitting for tasks, hitting, biting

If your child requires therapy, what are your personal goals/expectations? What would you like your child to learn? Please describe. Please add any other helpful information.

Interested in Telehealth? *

- ○ Yes
- ○ No
- ○ Blended

Preferred time and day

Emergency Contact Information

First name *

Last name *

Phone number *

Relationship to child *

Adults who are authorized to take your child to and/or from therapy.

First name *

Last name *

Phone number *

Relationship to child *

I hereby give my consent to the authorized person at Keiki Therapy LLC for the child (client) named above to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in the case of emergency when the parents or guardians cannot be reached.

☐ Agree *

Consent to Treat

I give permission for Keiki Therapy LLC to provide the medical treatment appropriate and necessary for the rehabilitation and/or habilitation of client's current physical condition, and/or therapy services needed.

- [ ] Agree *

Attendance Policy

Clients may be removed from the schedule for any of the following reasons: Three consecutive missed or canceled appointments, Two no-shows (i.e. missed appointments without a telephone call to cancel), or Inconsistent attendance (including arriving late for appointments).

- [ ] Agree *

Photo/Video Consent

Permission to use photograph(s) and/or video for evaluation, treatment, or publicity.

- [ ] Allow
- [ ] Do Not Allow

Privacy

Keiki Therapy LLC is committed to keeping all Protected Health Information and sensitive information secure and to keeping our systems and procedures up to date and in compliance with all related regulations.

Keiki Therapy LLC understands that you have read and are aware of the current rules and regulations regarding Patient Rights and Responsibilities. If you are unaware of these policies, please ask us for a copy. Any changes to the HIPAA Privacy Act, effective April 14, 2003, or patient rights will be posted in our office.

- [ ] Agree *

Signature *

Date *