SMILES Integrative Therapy Services

Client Intake Form

(Please Either Type or Print)

For Internal Use Only

Received by: Date:

Notes:

Parent/Guardian Address

Name: _____ Email: _____

Street: _____

City: _____ State: _____ Zip: _____

Parent/Guardian Phone Numbers

Cell Phone: ( ) _____

Home Phone: ( ) _____

Work Phone: ( ) _____

Second Parent/Guardian Address

Name: _____ Email: _____

Street: _____

City: _____ State: _____ Zip: _____

Second Parent/Guardian Phone Numbers

Cell Phone: ( ) _____

Home Phone: ( ) _____

Work Phone: ( ) _____

Emergency Contact

Name: _____ Email: _____

Street: _____

City: _____ State: _____ Zip: _____

Emergency Contact Phone Numbers

Cell Phone: ( ) _____

Home Phone: ( ) _____

Work Phone: ( ) _____

Child's Information

Name: _____ Gender: ◯ Male ◯ Female

Date of Birth: _____

Birth History/Complications: _____

_____

_____

_____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Child's Medications & Allergies

Medications/Supplements: _____

_____

_____

_____

Allergies (Environmental / Medical / Food / Suspected):

_____

_____

_____

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Child's Info (Continued)

Augmentative/Alternative Comm. Methods or Devices (Currently or previously used. Please list all and duration attempted.):

_____

Adaptive Equipment Currently & Previously Used at Home or School: _____

Child Wears Glasses: ◯ Yes ◯ No Child Wears Hearing Aids: ◯ Yes ◯ No

Potty Trained: ◯ Yes ◯ No How do they ask to go? _____

Developmental Milestones: (ex. crawling) _____

_____

Sibling(s) (Name & Age): _____

Motivating Activities/Objects: _____

Typical Day's Activities: _____

_____

Parental Goal for Evaluation/Therapy: _____

Current & Pevious School & Private Therapy

School: _____ School District: _____

IEP: ◯ Yes (Expiration: _____) ◯ No (Previous IEP Date: _____)

IEP Areas: ◯ Speech ◯ Language ◯ OT ◯ PT ◯ Social ◯ Reading ◯ Writing ◯ Math

Additional Current & Previous School Therapy & Activities (If any—list type and frequency): _____

_____

Current & Previous PrivateTherapy (If any—list type and frequency): _____

_____

Client Intake Form

(Please Either Type or Print)

Primary Physician

Physician's Name: _____ Phone Number: ( ) _____

Practice Name: _____

Street: _____ City: _____ State: _____ Zip: _____

ENT

ENT's Name: _____ Phone Number: ( ) _____

Practice Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Date of last hearing screening/test: ____/____/____ Results: _____

Other Specialist

Specialist's Name: _____ Phone Number: ( ) _____

Practice Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Dentist/Orthodontist

Dentist/Orthodontist's Name: _____ Phone Number: ( ) _____

Practice Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Ophthalmologist

Ophthalmologist's Name: _____ Phone Number: ( ) _____

Practice Name: _____

Street: _____ City: _____ State: _____ Zip: _____