Shaping Change

Patient Intake Form

(Please Print)

CONTACT PERSON INFORMATION	
Contact Person's Name:	**Today's Date**:
Relationship to Patient:	**Email**:
Home Phone:	**Cell Phone**:
Address:	
Chose clinic because / Referred to clinic by (please check one box): ☐ Dr. ____ ☐ Insurance plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other	

Intake Form checklist (PLEASE SUBMIT ALL DOCUMENTS BELOW):

☐ Completed and signed this Intake Form

☐ Attached copy of diagnostic reports/evaluations (must be within last 3 years)

☐ Attached copy of Educational Plan

☐ Attached copy (front and back) of insurance card (color copy)

☐ Attached copy of driver's license (color copy)

Fax completed Intake Form and copies of the above documents to 1(866)-883-9515 or drop off at our office. All information must be received prior to scheduling a consultation. Please do not send Protected Health Information (PHI) through email-we will not accept it.

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The following questionnaire is to be completed by the patient, the patient's parent or his/her legal guardian.

This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information that you think may be helpful in understanding your child. Shaping Change, LLC. will hold information provided by you is strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law.

Please use the backs of the pages for additional information.

PATIENT INFORMATION		
Patient's Name:	**Date of Birth**:	**Age**:
Gender: ☐ Male ☐ Female	**Race / Ethnicity** (check all that apply): ☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other	
Address:	**Email**:	
Home Phone:	**Cell Phone**:	
Occupation:	**Employer Name**:	**Employer Phone**:
Employer Address:		

PATIENT PARENTS / GUARDIANS INFORMATION		
Mother / Guardian Name:	**Date of Birth**:	**Age**:
Email:	**Race / Ethnicity**: ☐ White ☐ African ☐ Hispanic ☐ Asian ☐ Other	
Address:		
Home Phone:	**Cell Phone**:	
Occupation:	**Employer Name**:	**Employer Phone**:
Employer Address:		
Education Level Completed: ☐ Elementary School ☐ Middle School ☐ High School ☐ College/University		
Father / Guardian Name:	**Date of Birth**:	**Age**:
Email:	**Race / Ethnicity**: ☐ White ☐ African ☐ Hispanic ☐ Asian ☐ Other	
Address:		
Home Phone:	**Cell Phone**:	
Occupation:	**Employer Name**:	**Employer Phone**:
Employer Address:		
Education Level Completed: ☐ Elementary School ☐ Middle School ☐ High School ☐ College/University		
Are the parents/guardians divorced? ☐ Yes ☐ No (If yes, please provide a copy of the parental responsibility agreement)		

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PATIENT INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Name of person responsible for bill:	**Date of Birth**:	**Address**:		
Home Phone:		**Cell Phone**:		
Occupation:	**Employer Name**:		**Employer Phone**:	
Employer Address:				
Is this patient covered by insurance? ☐ Yes ☐ No		**Primary Insurance Provider**:		
Subscriber's Name:	**Date of Birth**:	**Group No.**:	**Policy No.**:	**Co-payment Amount**: $
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other				
Secondary Insurance Provider:				
Subscriber's Name:	**Date of Birth**:	**Group No.**:	**Policy No.**:	**Co-payment Amount**: $
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other				

PATIENT EDUCATIONAL INFORMATION

School Name (In chronological order)	**System**	**Year(s)**	**Grade**	**Special Ed?**

Name(s) of Current Teacher(s):

List concerns patient may have about the teacher(s):

Patient's Favorite Subject/Class:

Patient's Least Favorite Subject/Class:

Has patient ever repeated a grade? ☐ **Yes** ☐ **No**

If Yes, what grades?

If patient has been in Special Education, did they have: ☐ 504 Plan ☐ Psychological Evaluation ☐ Behavior Intervention Plan ☐ Physical Therapy Evaluation ☐ I.E.P. ☐ Speech Evaluation ☐ Occupational Therapy Evaluation ☐ Adaptive Technology Evaluation ☐ Other(s)

If patient has been in Special Education, how was he/she served? ☐ **Consultation** ☐ Collaborative Education ☐ Pull-Out ☐ Resource Classro ☐ Team Taught Classes ☐ Self-Contained Classroom ☐ Psychoeducational Center ☐ Special Program

Patient's Extracurricular Activities (sports, clubs, hobbies, lessons, etc.): ☐ Football ☐ Baseball ☐ Cheerleading ☐ Basketball ☐ Karate ☐ Piano ☐ Scouts ☐ Soccer ☐ Dance ☐ Music ☐ Gymnastics ☐ Other

Patient's special abilities, skills, strengths:

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PATIENT MEDICAL HISTORY INFORMATION

Diagnosis 1 (please provide a diagnosis):

Diagnosing Physician: | **Date of Diagnosis:**

Diagnosis 2 (please provide a diagnosis):

Diagnosing Physician: | **Date of Diagnosis:**

Diagnosis 3 (please provide a diagnosis):

Diagnosing Physician: | **Date of Diagnosis:**

Diagnosis 4 (please provide a diagnosis):

Diagnosing Physician: | **Date of Diagnosis:**

Relevant Hospitalizations:

Were developmental milestones met on time? ☐ Yes ☐ No

Abuse History:

Please list any prescription or non-prescription medication/supplements (if additional space is needed use the same format in the back of this page)

Medication/Supplement	Dose	Frequency	Reason	Prescribing Physician

PRESENTING PROBLEM INFORMATION

Please explain patient's presenting problem:

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FAMILY INFORMATION

Siblings

Name	**Age**	**Race**	**Relationship**	**Living in Home Yes / No**	**School Name**	**Grade**
				☐ ☐		
				☐ ☐		
				☐ ☐		
				☐ ☐		

Please list additional siblings using the above format in the back of this page.

Please indicate any special needs of concern regarding the other children living in your home:

Please indicate any concerns you have regarding the patient for whom you are seeking services and these siblings' relationship(s):

Others – List any other people who currently, or in the patient's lifetime, have lived in your home

Name	**Age**	**Race**	**Relationship to Patient**	**Years Living in Home (from – to)**
				–
				–
				–
				–

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SERVICES INFORMATION

Past Services

	Yes / No	Dates of Service (from – to)
ABA	☐ ☐	–
OT	☐ ☐	–
Speech	☐ ☐	–
PT	☐ ☐	–
Counseling	☐ ☐	–

Current Services

	Yes / No	Dates of Service (from – to)
ABA	☐ ☐	–
OT	☐ ☐	–
Speech	☐ ☐	–
PT	☐ ☐	–
Counseling	☐ ☐	–

STATEMENT

I understand this Patient Intake Form to aid in gathering information for effective treatment. If I choose not to seek services, any paperwork collected by Shaping Change, LLC. will be destroyed after 30 days.

Name:	**Signature**:	**Date**: