Child's Name:_____ Date of Birth:_____
Parent's Name(s):_____ Referred by:_____
Address:_____
Phone:_____ Alternative Phone:_____
Best time to call:_____ Email:_____
Best mode of communication: Circle at least one: TEXT EMAIL CALL
Form completed by:_____Date:_____

Availability:
Where would you like sessions to take place?
HOME SPECTRUM PEDS CLINIC DISCUSS WITH THERAPIST

Please indicate the days and times that would best fit your schedule for therapy visits. Please provide **at least three** options. We will do our best to accommodate your preference, but scheduling will be dependent on the therapist's availability, as well.

MONDAY:	Morning (8-12)	Afternoon (12-3)	Evening (3-6)
TUESDAY:	Morning (8-12)	Afternoon (12-3)	Evening (3-6)
WEDNESDAY:	Morning (8-12)	Afternoon (12-3)	Evening (3-6)
THURSDAY:	Morning (8-12)	Afternoon (12-3)	Evening (3-6)
FRIDAY:	Morning (8-12)	Afternoon (12-3)	Evening (3-6)

Pre-Assessment Questionnaire

Physical Development:

1. At what age did the child: (age in months)
   Sit alone: _____
   Walk alone: _____
   Toilet train: _____
   First word(s): _____
2. Is the child right or left handed?_____

Medical History:

1. Has the child had:

Disease/Condition	Date
Chicken Pox	
Measles	
Mumps	
Scarlet Fever	

Ear Infections	

3. Has the child ever been hospitalized? Yes No
   If yes, please explain_____
4. Has the child ever had a serious injury or surgery? Yes No
   If yes, please explain_____
5. Is the child currently taking any medications? Yes No
   If yes, please list_____
6. Has your child been diagnosed with any specific syndromes or developmental difficulties (i.e. Autism, Down syndrome, etc.)? Yes No
   If yes, explain_____
7. Are there any other specific medical needs regarding your child that we should know about (allergies, asthma, heart defect, etc.)? Yes No
   If yes, explain_____

Previous Evaluations:

1. Has your child had any previous evaluations for development? Yes No
2. If yes, please circle the assessments that have been completed.

Please provide copies of the evaluation(s) to the Practice Director. These need to be received before therapy can begin.

- Developmental Pediatrician (Date occurred:_____)
- Psychologist (Date occurred:_____)
- Speech-Language Therapy (Date occurred:_____)
- Occupational Therapy (Date occurred:_____)
- Physical Therapy (Date occurred:_____)
- Feeding team (Date occurred:_____)
- Nutritionist (Date occurred:_____)
- Special Education testing (Date occurred:_____)
- Other _____
- Other_____

Hearing & Vision

1. Do you suspect a hearing problem? Yes No
   If yes, why?_____
2. Has your child ever had his/her hearing tested? Yes No
   If yes, when?_____ Results_____
3. Do you suspect a vision problem? Yes No
4. Has your child ever had his/her vision tested? Yes No
   If yes, when?_____ Results_____

Birth History

1. Was the pregnancy full term? Yes No
   If no, explain?_____
2. Were there complications with the pregnancy or mother's health during pregnancy? Yes No
   If yes, explain:_____
3. Age of mother at time of delivery _____

4. Length of labor _____
5. Was the delivery:
   Normal _____
   Breech _____
   C-Section _____ If C-Section, why?_____
6. Were there any complications during delivery? Yes No
   If yes, explain?_____
7. Birth weight _____
8. Condition of child at birth_____
9. Any problems with the child during the first few months of life? Please describe:
   _____
   _____
   _____

Educational History

1. Present school? _____
2. Present grade? _____
3. Present teacher? _____
4. Does your child currently receive special services at school/home? Yes No If yes, does your child have one of the following: IEP IFSP 504 Plan
5. Year child started school? _____
7. Does the classroom teacher report any difficulties Yes No If yes, please describe _____
   _____
   _____
8. School grades are: ____Superior
   ____Average
   ____Below Average
   ____ Not applicable
9. Best Subjects _____
10. Weak Subjects _____

Social History

1. Who lives in the home with the child?

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Who, besides parents, cares for the child? _____
   _____
   _____
   _____
3. Describe the child's personality?
   _____

_____

4. How does the child get along with: Siblings _____
   Adults _____
   Peers _____

5. Please check as many of the following areas that pertain to your child's development:

   A. SPEECH LANGUAGE: ○ The speech sounds are incorrect or slushy.
   - ○ I have trouble understanding my child's speech. ○ My child should be using more words and/or longer sentences. ○ My child has trouble understanding social situations. ○ My child has a repaired cleft lip/cleft palate. ○ My child has difficulty understanding language/directions.
   - ○ My child stutters and gets "stuck" on words/sounds. ○ The child has been or is exposed to more than one language.
   - ○ My child is non-verbal.
   - ○ My child's voice does not sound appropriate (nasal, raspy, etc.). B. FEEDING:
   - ○ My child is currently on a feeding tube. G-tube NG-tube Other ○ My child is a picky eater. ○ My child has difficulty eating solid foods. ○ My child aspirates (food/liquids go into lungs).
   - ○ My child has had a swallow study completed. Results:_____ ○ I have to force feed my child to get him/her to eat.
   - ○ My child gags or vomits often when eating. C. FINE MOTOR:
   - ○ My child struggles with writing tasks (pencil grip, neatness, fatigues easily, formation of letters, etc.).
   - ○ My child struggles with self-help skills (closing snaps, using buttons, using zippers).
   - ○ My child favors one hand over the other.
   - ○ My child has difficulty using utensils.

   D. GROSS MOTOR: ○ My child is not crawling and pulling up. ○ My child has trouble sitting up. ○ My child favors looking one way over the other.
   - ○ My child has difficulty with walking (unstable, incorrect gait).
   - ○ My child has difficulty with throwing/catching.
   - ○ My child has difficulty climbing stairs.

   E. SENSORY: ○ My child is sensitive to light, sounds, or textures.
   - ○ My child seems to need to move around constantly.
   - ○ My child seems unaware when he/she is touched or bumped.
   - ○ My child seems clumsy, floppy, or uncoordinated. F. BEHAVIORS: ○ My child has difficulty holding eye contact. ○ My child has difficulty holding attention. ○ My child is aggressive. ○ My child has difficulty with transitions (new people, trips out in the community, etc.).

Any other concerns not listed above? Please share here:_____
_____
_____
_____

6. What goals are you hoping for your child to achieve with Spectrum Pediatrics?

_____

_____

_____

_____

Physicians

Please list any physicians who are currently treating your child

Physician's Name	Specialty	May We Contact?		Phone or Email
		Y	N	
		Y	N	
		Y	N	
		Y	N	
		Y	N	

Therapists and Other Professionals

Please list any other professionals who are currently working with your child. Examples of professionals are: school personnel, SLP, OT, PT, nutritionist, behavioral therapists

Professional's Name	Specialty	May We Contact?		Phone or Email
		Y	N	
		Y	N	
		Y	N	
		Y	N	
		Y	N	

Are there any therapies/services that have been discharged or terminated? Please list therapy and reason for termination of services:

Service	Termination Date	Reason for Termination

Is there any other information not covered in this intake form that you would like to share with us?

_____

_____

_____

Consent for Services

I, _____ (parent/guardian), give my permission to Spectrum Pediatrics, LLC to exchange information about _____ (child/client) with the physicians, programs, and other persons I have indicated above. I also give permission to Spectrum Pediatrics, LLC to provide evaluation, treatment, and consultative services to the above mentioned child.

I understand that fees for services provided are due at the time of treatment.

_____ _____

Parent/Legal Guardian Date

_____ _____

Witness Date

spectrum pediatrics

Fee Schedule
Effective January 1, 2018

SERVICE	OFFICE	HOME
Speech-Language Therapy Services		
Speech-Language Evaluation	$450.00	$450.00
PROMPT Evaluation only (Must have a completed speech-language eval to qualify)	$200.00	$200.00
Speech-Language treatment session or consultation	$125.00	$135.00
Feeding therapy treatment session or consultation	$150.00	$150.00
Occupational Therapy Services		
Occupational Therapy Evaluation	$450.00	$450.00
Occupational Therapy treatment session or consultation	$125.00	$135.00
Feeding therapy treatment session or consultation	$150.00	$150.00
Physical Therapy Services		
Physical Therapy Evaluation	$450.00	$450.00
Physical Therapy treatment session or consultation	$125.00	$135.00
Special Education Services		
Special Education /Behavior Evaluation	$450.00	$450.00
Special Education/Behavior treatment session or consultation	$125.00	$135.00
Nutrition Services		
Nutrition Evaluation	$450.00	$450.00
Nutrition treatment session or consultation	$150.00	$150.00
Miscellaneous Services		
Re-Assessment (any discipline)	$300.00	$300.00
Group Therapy	VARIES	VARIES
Team Meeting Attendance (per hour)	$135.00	$135.00
Non-Treatment Documents & Resource Development (all disciplines)	$150.00	$150.00
Photo copies of Medical Records (beyond 5 pages)	$ 25.00	$ 25.00

Evaluations include written reports and initial consultations and vary in length depending on individual child's needs. Please allow 10 working business days from date of evaluation for therapist to deliver report. Spectrum Pediatrics requires yearly reevaluations in order to continue the best treatment plan possible for your child.
Treatment sessions or consultations range in length from 45 minutes to 1 hour as determined by the therapist.

Payment Information: Payment is due at the time that services are rendered. Spectrum Pediatrics, LLC does not accept payment from third party providers (i.e. health insurance companies, school districts, counties).

Payment & Cancelation Agreement

I, _____ (parent/guardian), acknowledge and accept full and complete responsibility for prompt payment of all services rendered to _____(child/client) by Spectrum Pediatrics, LLC.

I agree that payment in full is due at the time of treatment. Additionally, I understand that I will be assessed a $30.00 fee for any payments returned to Spectrum Pediatrics, LLC.

I have been informed by Spectrum Pediatrics, LLC of the following charges regarding cancelations:

- No fee will be charged for cancelations made 24 hours prior to scheduled appointments
- A $30 fee will be charged for cancelations made less than 24 hours prior to scheduled appointments and those made up to one hour before scheduled therapy time on day of scheduled appointment.
- A full session fee will be charged for visits:

I. canceled less than 1 hour before the scheduled therapy time;

II. if the therapist shows up and no one is available for therapy; or
if your child arrives sick

1. has a fever,
2. is too sick to participate in therapy or
3. the therapist deems the session cannot continue because the child is too sick

I understand that if I cancel scheduled sessions three (3) times in a six (6) month period services may be suspended. Following, there is a meeting with our current therapist, a member of the management team and the family, to discuss services.

If you call to cancel your child's scheduled appointment, please contact your therapist directly and leave the following information: Your child/children(s) full name, appointment date(s) and appointment time(s). If you cannot reach your therapist, please contact the office at: 703-299-0051

I acknowledge that I have received written explanation of the fee structure and the cancelation policy and I agree to both.

The fees that I am charged by Spectrum Pediatrics, LLC are in no way related to health insurance or educational reimbursement. I understand that I am personally responsible for direct payment to Spectrum Pediatrics, LLC, regardless of any reimbursement issues that I choose to investigate.

_____ _____

SIGNATURE (parent or legal guardian) DATE

Photo & Video Release Form

I agree that Spectrum Pediatrics, LLC may use photos or video footage of me/my child for to treatment purposes.

I have read and understand the foregoing statement. I agree to its contents and it is my intent to be bound by this Release.

Signature, parent or guardian _____
(if under 18)

Printed name _____

Child's name _____

Address _____

Date _____