DATE CALLED_____ WHO TOOK CALL_____

INTAKE FORM

To Be Completed by Therapy Junction:

Starting with:_____

_____

_____

Evaluation Date:_____

Preferred Paperwork Method:

- ☐ Emailed Printable
- ☐ Emailed Fillable
- ☐ Mailed

Send By:

- ☐ Admin
- ☐ Scheduling Manager

Name:_____

DOB:_____

Caregiver's Name (if applicable):_____

Address:_____

_____

Email Address: _____

Phone number:_____ **Can we text this number?** Yes: ◯ No: ◯

Physician Diagnosis(s):_____

Physician Name:_____

Clinic/Office:_____

Discipline(s) Requested: Occupational Therapy ☐ Speech Therapy ☐ Physical Therapy ☐

Specialties Requested: Aquatic Therapy ☐ MNRI/Reflexes ☐ AAC ☐ Feeding Therapy ☐ Pelvic Floor ☐

Primary Concerns:

_____

_____

_____

_____

Concerns with Any of these?:

PT	***OT***	***SLP***
☐ Gross Motor Skills	☐ Fine motor skills	☐ Following Directions
☐ Balance	☐ Coordination	☐ Stuttering
☐ Functional Mobility	☐ Self Care Skills	☐ Difficult to Understand
☐ Strength	☐ Sensory Procesing	☐ Social Skills
☐ Activity Tolerance	☐ Emotional Regulation	☐

Safety Concerns: None ☐ Seizure Disorder ☐ Diabetes ☐ Major Allergy ☐ Behaviors ☐ Other ☐

Please Describe:_____

_____

PRIMARY INSURANCE		SECONDARY INSURANCE	
Carrier:	Private Pay	Carrier:	Not Applicable
Member ID:		Member ID:	
Group #:		Group #:	
Provider Phone #:		Provider Phone #:	
Policy Holder Name:		Policy Holder Name:	
Policy Holder DOB:		Policy Holder DOB:	

Referred By:_____

Do you currently receive any services outside of Therapy Junction? YES ◯ **NO** ◯

If yes list:

_____

_____

Scheduling Times:

Preferred Days: Monday: ☐ Tuesday: ☐ Wednesday: ☐ Thursday: ☐ Friday: ☐

Preferred Times:

Early Morning (8-9 AM) ☐

Mid-Morning (10-11AM) ☐

Mid-Afternoon (1-2 PM) ☐

Late Afternoons (3 PM or Later) ☐

More Specific… Please list days and times available in order of preference:

_____

_____

_____

AdditionalComments:_____

_____

_____

_____