Dear Parent(s)/Guardian,

Welcome to the Occupational Therapy and Speech Therapy Departments at SunnyDays Therapy Inc. We are excited that you have shown an interest in our services and look forward to meeting you. To begin the intake process, we will need additional information from you. We ask that you review the enclosed information, and complete the intake forms. Please fill in the blanks as thoroughly as possible. You may also provide additional information that we have not asked for if you feel it would be helpful for the evaluation and treatment process. We will also need a copy of both the front and back of your insurance card.

Upon completion of these forms, you will be contacted to set up an evaluation date and time for your child if you have not already done so.

Thank you for your interest in SunnyDays Therapy. We are excited to meet you and your child and to begin the evaluation process. If you have any questions, please do not hesitate to contact us at 952-223-2506.

Thank you,

The SunnyDays Therapy Team

Phone: (952) 223-2506
Fax: (952) 443-2038
www.SunnyDaysTherapy.com

Minnetonka
15265 Minnetonka Blvd
Minnetonka, MN 55345

Waconia
9346 Oak Avenue
Waconia, MN 55387

St. Michael
403 Central Ave E, Suite 102
St. Michael, MN 55376

Registration Form

1. Patient Information

Child's Full Name: _____ **DOB:** _____ Gender: F / M

Person Completing this form: _____ Relationship to Child: _____

Street Address: _____

City:_____ State: _____ Zip: _____

Primary Physician: _____

Clinic Name: _____Physician Phone: _____

Emergency Contact: _____ Relationship to Child: _____

Phone: _____ Alternate Phone: _____

Caregiver (1) Name: _____Relationship: _____

Phone: _____E-Mail: _____

Preferred Contact Method: ❑Home ❑ Phone ❑ E-Mail ❑ Phone

Caregiver (2) Name: _____Relationship: _____

Phone: _____E-Mail: _____

Preferred Contact Method: ❑Home ❑ Phone ❑ E-Mail ❑ Phone

Would you like text message appointment reminders?

❑YES ❑NO

❑Day Before Appt or ❑Day of Appt

❑Caregiver 1 Cell
❑Caregiver 2 Cell
❑Both

2. Payment Information

Primary Insurance Co: _____

Subscriber/ID Number: _____ Group/Policy Number:_____

Policy Holder Name: _____ Relationship to Child _____

Policy Holder DOB: _____

Secondary Insurance Co: _____

Subscriber/ID Number: _____ Group/Policy Number:_____

Policy Holder Name: _____ Relationship to Child _____

Policy Holder DOB: _____

3. Invoice Delivery Preference

How would you like your invoice delivered? ❑ E-mail ❑ Mail

E-mail address: Same as Above ❑ or:

_____

Billing address: Same as Above ❑ or:

Street Address: _____

City: _____ State: _____ Zip: _____

Invoices are sent out each month, however, you are welcome to pay your bill at any time in the office or online at www.patientnotebook.com/sunnydays/payment

- I understand that I am financially responsible for payment of any services provided by SunnyDays Therapy Inc, including co-pays, deductibles, and co-insurance.
- I request that payment of authorized insurance benefits be made to SunnyDays Therapy Inc for any services furnished to my child.
- I authorize SunnyDays Therapy Inc to release and/or exchange any information with other providers/organizations who are involved in my child's treatment.
- I acknowledge that I have been given the opportunity to read and/or received SunnyDays Therapy Inc Notice of Privacy Practices.
- This authorization and assignment will remain in effect until revoked by me in writing.

Patient/Guardian signature _____ Date _____

4. How did you learn about SunnyDays Therapy?

❑ Web search ❑ Friend/Relative: _____

❑ Doctor: _____ ❑ Insurance Company: _____

❑ Other: _____

5. Release of Information

Who do you authorize SunnyDays Therapy to communicate with about your child?

❑ Parent(s)/Guardian: _____

❑ Relative(s): _____

❑ Other: _____

Please list any communication restrictions:

_____

6. Family Information

Child lives with (check one):

❑ Birth Parents ❑ Foster Parents ❑ One Parent

❑ Adoptive Parents ❑ Parent and Step-Parent ❑ Other _____

Siblings:

Name	Age	Learning & Medical Problems *If Applicable*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is there a history on either side of the child's family for significant diagnoses or medical conditions?

❑ Autism/PDD ❑ ADHD ❑ Learning Disabilities

❑ Hearing Loss ❑ Stuttering ❑ Speech/Language Delays

❑ Mental Health ❑ Other _____

6. Family Information, continued...

Is there a language(s) other than English spoken in the home? ❑ Yes ❑ No

If yes, what language(s)? _____

Does the child speak the language? ❑ Yes ❑ No

Does the child understand the language? ❑ Yes ❑ No

Who speaks the language? _____

Which language does the child prefer to speak at home? _____

Please list any cultural or religious considerations you would like SunnyDays to be aware of that would help us best serve your family…

_____

_____

7. Patient Background

Please describe developmental or behavioral concerns regarding your child:

_____

_____

When did you first have concerns about your child?_____

Please list your child's strengths: _____

_____

Please list areas that you would like to see your child gain more independence in:

_____

_____

What types of activities/toys are reinforcing or enjoyable for your child? _____

_____

8. Birth History

Was your child born full term? ❑ Yes ❑ No **Number of Weeks Premature:** _____

Child's delivery was: ❑ Vaginal ❑ Cesarean ❑ Forceps ❑ Suction

Describe any problems during pregnancy, labor or delivery: _____

_____

Birth Weight: _____ **Was oxygen required**? ❑ Yes ❑ No If yes, how long? _____

Please list any medical problems at birth: _____

_____

9. Medical Information

Has your child received a Medical diagnosis?

(e.g., Attention Deficit Disorder, Autism Spectrum Disorder) ❑ Yes ❑ No

If yes, please list diagnosis: _____

Date of diagnosis : _____

Diagnosis made by: _____

Please answer the following questions about your child:

❑ Seizures: If yes, explain _____
❑ Sleep Problems: If yes, explain _____
❑ Vision Problems: If yes, explain _____
❑ Tested: Pass or Fail
❑ Hearing Problems: If yes, explain _____
❑ Tested: Pass or Fail
❑ Ear infections: If yes, how often/many _____
❑ Ear tubes: If yes, when? _____
❑ Feeding Problems: If yes, explain _____
❑ Oral surgery: If yes, explain _____
❑ Head Injury: If yes, explain _____
❑ High Fevers: If yes, explain _____
❑ Chicken Pox: If yes, explain _____
❑ Meningitis: If yes, explain _____
❑ Special Diet: If yes, explain _____
❑ Cleft Lip/Palate If yes, explain _____
❑ Tonsillectomy If yes, explain _____
❑ Tongue/Lip Tie If yes, explain _____
❑ Other: _____

Does your child have any allergies? ❑ Yes ❑ No

Please list: _____

Current Medication(s), please list below:

Type of Mediation Dose Reason

_____

_____

_____

10. Physical Development

Developmental History:
Please indicate the age at which your child achieved the following developmental milestones. (Mark N/A if your child has not yet attained a particular skill)

Smiled	_____	Dressed Self	_____
Rolled	_____	Fed Self	_____
Sat alone	_____	Toilet Trained	_____
Stood Alone	_____	Used crayon to color	_____
Crawled	_____	Single Words:	_____
Walked alone	_____	Short phrases:	_____

Additional Comments:

_____
_____

11. Communication Methods

How does your child communicate? (Please check all that apply)

- ❑ Crying
- ❑ Pointing with finger
- ❑ Pulling/Directing to need/want
- ❑ Sounds
- ❑ Words
- ❑ Phrases
- ❑ Sentences
- ❑ Sign Language
- ❑ Picture Communication Boards
- ❑ Alternative or Augmentative Device (e.g., iPad, Dynavox, picture book)

Additional Comments:

_____
_____

12. School & Therapy Services

Does your child attend school? ❑ Yes ❑ No
Name of school and address (if applicable):

_____
_____

Current Grade: _____ **Teacher:** _____

Type of Classroom: _____

What are your child's strengths at school?

_____
_____

12. School & Therapy Services, continued...

Does your child receive the following special services at school?

- ❑ Physical Therapy
- ❑ Occupational Therapy
- ❑ Speech Therapy Other, specify_____
- ❑ Adaptive PE
- ❑ Resource Room/special instruction

Age child started receiving special services: _____

Is your child currently receiving any services outside of school (please list)**?**

_____

_____

_____

_____

Please list previous services or programs your child has participated in along with approximate dates of service (i.e., PT, OT, listening programs, brushing etc.)

_____

_____

_____

Please list your appointment availability:

Monday	Tuesday	Wednesday	Thursday	Friday
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Additional Information

Please list additional information that you think would help us get to know your child better:

_____

_____

_____

_____

_____

_____

Thank you for helping us get to know your child!