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

Registration Form

1. Patient Information

Child's Full Name _____DOB: _____ Gender: ____M ____F

Name of Person Completing this form: _____

Relationship to child: _____

Home Phone: _____ Alternate Phone: _____

Street Address _____ City _____ State _____ Zip _____

Primary Physician _____ Clinic Name _____

Physician Phone _____

Emergency Contact _____ Relationship _____

Phone _____ Alternate Phone _____

Mother's Name:_____ Phone: (_____)_____-_____Email: _____
Preferred contact method: [] Home Phone [] E-Mail [] Phone [] Other _____

Father's Name:_____ Phone: (_____)_____-_____Email: _____
Preferred contact method: [] Home Phone [] E-Mail [] Phone [] Other _____

Would you like text message appointment reminders? ☐YES ☐NO If yes, ☐Day Before Appt or ☐Day of Appt

☐Mother Cell ☐Dad 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:

_____

What is your billing address? Same as Above ☐

Street Address: _____ City: _____

State: _____ Zip: _____

- Invoices are sent out the 5th of 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: _____
_____

6. Family Information

Mother's Name: _____ Father's Name: _____

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?_____
_____
_____
_____.

7. Patient Background

Please describe developmental or behavioral concerns regarding your child:
_____
_____

Please list your child's strengths:_____
_____

Please describe your child:_____
_____
_____

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:	Yes_____No_____	If yes, explain_____
Sleep Problems:	Yes_____No_____	If yes, explain_____
Vision Problems:	Yes_____No_____	If yes, explain_____
Tested:	Yes_____No_____	If yes, results: Pass or Fail
Hearing Problems:	Yes_____No_____	If yes, explain_____
Tested:	Yes_____No_____	If yes, results: Pass or Fail
Ear infections:	Yes_____No_____	If yes, how often/many_____
Ear tubes:	Yes_____No_____	If yes, when?_____
Feeding Problems:	Yes_____No_____	If yes, explain_____
Oral surgery:	Yes_____No_____	If yes, explain_____
Head Injury:	Yes_____No_____	If yes, explain_____
High Fevers:	Yes_____No_____	If yes, explain_____
Chicken Pox:	Yes_____No_____	If yes, explain_____
Meningitis:	Yes_____No_____	If yes, explain_____
Special Diet:	Yes_____No_____	If yes, explain_____
Allergies:	Yes_____No_____	If yes, explain_____

Other:_____

Is your child currently taking medication(s), please list below:

Type of medication 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 and 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? _____
_____
_____

Does your child receive the following special services at school?
Physical Therapy _____ Adaptive PE ____
Occupational Therapy_____ Resource Room/special instruction ____
Speech Therapy _____ Other, specify_____

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.)_____
_____
_____

13. 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!