DATE CALLED_____ WHO TOOK CALL_____

INTAKE FORM

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***
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

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:_____

_____

_____

_____