



Dear Parent(s)/Guardian,

Welcome to the Occupational Therapy Department 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 are currently receiving occupational therapy services at another facility we will need to obtain a copy of your discharge report from that facility prior to starting services at SunnyDays Therapy.

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,

Kelly Peters, MA OTR/L

Kelly Peters, MA OTR/L
Phone: 952-223-2506
Fax: 952-443-2038
Kelly@SunnyDaysTherapy.com



Registration Form

1. Patient Information

Child's full name: _____ Child's DOB: _____ Child's Gender: M F

Name of person completing this form: _____

Relationship to the child: _____

Home Phone: _____ Alternate Phone: _____

Address _____ City _____ State _____ Zip _____

Primary Physician: _____
Name _____ Clinic Name _____

Physician Phone: _____

Emergency Contact _____

Name _____ Relationship _____ Home 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 _____

2. Payment Information

Please check method of payment

- CASH**
I am paying out-of-pocket for services.
- INSURANCE**
Please include a copy of your insurance card

Primary Insurance Name _____ Policy Holder _____
Group Number _____ Policy Holder's Date of Birth _____
Identification Number _____

Secondary Insurance Name _____ Policy Holder _____
Group Number _____ Policy Holder's Date of Birth _____
Identification Number _____

- 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 _____



1. Patient Information

Child's full name: _____ Child's DOB: _____
Child's diagnosis: _____ Date of diagnosis: _____
Diagnosis made by: _____

2. Family Information

Mother's Name: _____ Father's Name: _____
Siblings: _____
Name Age Learning & Medical Problems If Applicable

3. 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? _____

4. 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: _____

5. Family History

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

6. Medical Information

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 _____
Hearing Problems: Yes _____ No _____ If yes, explain _____
Feeding Problems: Yes _____ No _____ If yes, explain _____
Special Diet: Yes _____ No _____ If yes, explain _____

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

Type of medication	Dose	Reason
_____	_____	_____
_____	_____	_____

7. 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: _____

8. Communication Methods

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

___ Crying	___ Sentences
___ Pointing with finger	___ Sign Language
___ Pulling/Directing to need/want	___ Picture Communication Boards
___ Words	___ Electronic Talking Devices
___ Phrases	

