|  |
| --- |
| **RE:** Occupational Therapy Services for our childHello,We would like to welcome you to Kids OT, Inc. Please complete all documentation and insurance forms and return via mail. (original signatures required by law). Once received you will be contacted to schedule Your Child’s evaluation appointment.Please Read, Complete and Sign (if needed) each form carefully. **Please BRING THE FOLLOWING INFORMATION With you TO EVALUATION Appointment:**1. Primary & Secondary Insurance Cards
2. A copy of Your Child’s IEP or other outside medical reports. (we can make copies here if needed)
3. Co-Pay (if required) needs to be cash or check only
4. All your questions and concerns regarding Your Child and ways that Kids OT, Inc. can help.

We look forward to meeting with you and Your Child. Sincerely,Kids OT, Inc. 72 Southbridge RoadCharlton, MA 01507(5-8) 248-6535(508) 248-7972 FaxOTKIDS@aol.com[www.kidsotinc.org](http://www.kidsotinc.org) |

Kids OT, Inc. REGISTRATION & CONSENT FORM

**CLIENT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Client First Name:** |  | **Client Last Name:** |  |
| **Date of Birth:** |  | **Primary Diagnosis:** |  |
| **Age:** |  | **Gender:** |  |
| **School:** |  | **Grade:** |  |
|  |  |  |  |
| **Parent 1 Name:** |  | **Parent 1 Cell #:** |  |
| **Parent 2 Name:** |  | **Parent 2 Cell #:** |  |
| **Address:** |  | **Home Phone #:** |  |
| **Town & Zip:** |  | **Primary E-Mail:** |  |

**INSURANCE INFORMATION**

|  |  |
| --- | --- |
| **PRIMARY** | **SECONDARY** |
| **Primary Insurance:** |  | **2ND Insurance:** |  |
| **Primary ID #:** |  | **2ND ID #:** |  |
| **Member Name:** |  | **2ND Member Name:** |  |
| **Member DOB:** |  | **2ND Member DOB:**  |  |

**MEDICAL INFORMATION**

|  |  |
| --- | --- |
| **PRIMARY PHYSICIAN** | **REFERRING PHYSICIAN** |
| **Name:** |  | **Name:** |  |
| **Phone #:** |  | **Phone #:** |  |
| **Fax #:** |  |  |  |

**CONSENT TO TREATMENT**

I hereby authorize the professional staff at Kids OT, Inc. to examine and provide Occupational Therapy to my child, Child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for the condition prescribed by the Primary Care Physician.

|  |  |
| --- | --- |
|  |  |
| Parent / Guardian / Client (Signature) | Date |

**RELEASE OF INFORMATION**

When Your Child’s evaluation report is completed, Kids OT, Inc. staff will:

* Mail the original signed copy to Parents/Guardians
* and, Fax a copy to Your Child’s primary physician, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Dr.’s Name).

If there are other agencies that you would like Kids OT, Inc. staff to communicate with, a release form is required to maintain your privacy.

I/We, Parents/Guardians, authorize Kids OT, Inc. to release records to the following people. This authorization is valid for 1 Full Year from evaluation date and may be revoked at any time in writing prior to the expiration date. Additional Authorization for re-disclosure beyond recipient is required.

Please provide the following information for each agency:

|  |  |  |  |
| --- | --- | --- | --- |
| **RELEASE # 1** |  |  |  |
| **Agency Name:** |  | **Work Phone:** |  |
| **Contact Person’s Name:** |  | **Fax:** |  |
| **Address:** |  | **E-Mail:** |  |
| **City, State, Zip:** |  | **Website:** |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent / Guardian / Client (Signature) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |

|  |  |  |  |
| --- | --- | --- | --- |
| **RELEASE # 2** |  |  |  |
| **Agency Name:** |  | **Work Phone:** |  |
| **Contact Person’s Name:** |  | **Fax:** |  |
| **Address:** |  | **E-Mail:** |  |
| **City, State, Zip:** |  | **Website:** |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent / Guardian / Client (Signature) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |

**AUTHORIZATION TO USE & DISCLOSE CLIENT INFORMATION**

As a client of Kids OT, Inc. you have the right to know how we may use and disclose information about you and your child. Information about our disclosure is provided in our Notice of Client Privacy Practices and a copy of this notice has been provided to you. You have the right to review our notice before signing this form.

You should read our Notice carefully before signing this form as our Notice of Privacy Practices explains that we need your authorization to use or disclose information about you or your child for any purpose other than treatment, payment or normal healthcare operations.

* I authorize the use and disclosure of my child’s protected health information for the following purposes:
* Basis of planning your child’s care and treatment
* Means of communication among the health professionals participations in your child’s care.
* Legal document describing the care you received.
* Means by which you or a third-party payer can certify that the services billed were actually provided.
* A source of information for public health officials charges with improving the health of the nation.
* A tool with which we can assess and continually work on to improve the care we deliver and the outcomes we achieve.
* I authorize the use and disclosure of the following types of protected health information that may pertain to any health care my child has received to date: my child’s entire occupational therapy record and information related to diagnosis and occupational therapy treatment.
* I authorize my protected health information to be disclosed to my Insurance Company, my child’s primary care physician and/or other healthcare providers and my Attorney.
* I HAVE BEEN TOLD THAT INFORMATION OTHERWISE PROTETED BY LAW AND DISCLOSED UNDER THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE AND MAY NO LONGER BE PROTECTED BY LAW, INCLUDING BUT NOT LIMITED TO PRIVACY REGULATIONS ISSUED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.
* I agree that this authorization for use and disclosure of my child’s identifiable health information will be effective from the date I sign this document until this authorization expires or until I revoke this authorization. I understand that I may revoke this authorization at any time by giving Kids OT, Inc. a notice in writing at 72 Southbridge Road; Charlton, MA 01507. I also understand that treatment, payment, enrollment in a health plan, of eligibility for certain health benefits cannot be conditioned on my providing this authorization. This authorization will expire one year from date of signature. By signing below, I agree that my protected health information may be used or disclosed as described above.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Parent / Guardian / Client (Printed Name) |  | Child’s Name |
|  |  |  |
| Parent / Guardian / Client (Signature) |  | Date |

**Client Policy**

|  |
| --- |
| Welcome To Kids OT, Inc., Your Child’s success at Kids OT, Inc. depends on your personal commitment. Because we want you and Your Child to have the most successful rehab experience possible, we would like to stress the importance to make Occupational Therapy a priority. Your therapist will provide you with recommendations for treatment and Your Child’s progress can be most successful when can attend all the recommended appointments in the most optimal state of health. Kids OT, Inc. Staff take pride in maintaining a healthy environment for all our clients. Children Learn Best When They Are Well Rested And In A Good State Of Health As Do Adults. For All Our Clients To Have The Most Successful Therapeutic Experience Kids OT, Inc. has Developed the Following Policy Guidelines: 1. If Your Child exhibits the following signs/symptoms we recommend that you re-schedule the appointment and let Your Child stay home to heal.
	1. If Your Child has a Fever.
	2. If Your Child has weepy runny eyes (not allergy related).
	3. If Your Child’s nasal discharge is other than clear, i.e. green or yellow in color.
2. For All Cancellations or Not Show Up for Scheduled Appointments Kids OT, Inc. Will:
	1. Charge you $30.00 each time a Cancellation is made within **24 HOURS** prior to your scheduled appointment. Kids OT, Inc. will be happy to help you re-schedule at your earliest convenience to avoid this cancellation fee.
	2. Charge you $30.00 each time a Cancellation is made **THE SAME DAY** as your scheduled appointment. Kids OT, Inc. will be happy to help you re-schedule at your earliest convenience to avoid this cancellation fee.
	3. Following 3 Consecutive No Shows or Cancellations or Later than 15 minutes, a notice will be sent to You and Your Child’s PCP of non-compliance of prescribed OT. Your Child will be discharged from their regular appointment time and Kids OT, Inc. Staff Suggest that you resume when you are able to make this commitment for Your Child.
3. During Your Child’s scheduled appointments, Kids OT, Inc. Staff will:
	1. Encourage Parents to participate in play with us. This helps us teach and address concerns regarding OT needs within all environments or,
	2. You can sit and wait in the waiting area to relax or work (Wi Fi provided), or
	3. Step outside to wait in your vehicle or in good weather sit out in the back yard to relax, or
	4. Provided Adult Accompaniment, siblings are welcome to come in to play space.
4. Parents are Required to Remain on the Premises during scheduled treatment sessions.

*(This does not apply to self-pay, speak to your therapist should an issue arise)* 1. Kids OT, Inc. video tapes during treatment sessions. Your Child’s Surveillance/Videos/Pictures will be deleted in 2 weeks.
2. Kids OT, Inc. staff teach annually throughout the USA and uses collected videos for educational purposes. A separate photo form is required for this. If your child’s videos are used for teaching purposes, a Photo Release Form will be provided.
3. Kids OT, Inc. will be closed for the following Holidays: New Year’s Day, Labor Day, July 4th, Memorial Day, Thanksgiving Day & Christmas Day. Additional Closing Notices will be provided as necessary. Therapy sessions are re-scheduled accordingly.
4. **SNOW CLOSINGS:** When The Majority of Local Schools (i.e. Auburn, Charlton, Southbridge, Leicester, Sturbridge, Spencer, Worcester) are Cancelled For Inclement Weather, Kids OT, Inc. Will Also Close. Individual Calls Will Be Made For Saturdays Appointment Cancellations.
5. Each visit is a standard 50-minute clinical hour. Benefits for Insurance vary in what is offered and once the initial authorized visits stop the re-authorization process begins. At this time delays in services may occur. Because most children progress well with consistency Kids OT, Inc. is willing to provide staff for 1 additional visit at no cost. If the insurance’s re-authorization process continues to delay and you wish to continue services, then Kids OT, Inc. can offer a discounted self-pay rate during the interim.

*(Please feel free to ask* Kids OT, Inc. *staff at any time to discuss your insurance plan’s benefits or if there are any financial concerns)*We appreciate you greatly as our client and strive to accomplish wonderful results and success for Your Child and You. |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Parent / Guardian / Client (Printed Name) |  | Child’s Name |
|  |  |  |
| Parent / Guardian / Client (Signature) |  | Date |

Verification of Insurance Benefits

Your benefits are determined by your individual plan, however, this is the information we have been able to obtain regarding your coverage.

**\*PLEASE NOTE -This information is NOT a guarantee of payment by your insurance carrier. Final determination of payment will be made once your claim is reviewed by your insurance carrier. It is your responsibility to be aware of your policy benefits and restrictions. We encourage you to contact your insurance company directly with any questions regarding your coverage.\***

You have asked us to bill\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for Occupational Therapy.

|  |  |
| --- | --- |
| **COPAY:** | Your Copay is $\_\_\_\_\_\_\_\_\_ per visit.It is our policy to collect co-pays at the time of service. We do not bill for co-pays. We accept CASH or CHECKS. |
| **CO-INSURANCE:**  | \_\_\_\_\_\_\_\_\_\_ will cover \_\_\_\_% of your bill. You will be responsible for the additional \_\_\_ %. We strongly encourage you to pay $\_\_\_\_\_\_\_\_\_\_\_ towards your portion of the balance. |
| **DEDUCTIBLE:**  | Your yearly medical deductible of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is your responsibility to pay.Your insurance will not pay for any visits until your deductible is paid.\*\*\* **Your account will not be allowed to exceed $200 unless previously agreed upon by both parties \*\*\*** |
| **HMO Standard Benefits:** | A Primary Care Physician Referral is required for the first \_\_\_\_\_\_\_\_\_\_\_\_\_ visits. You, as the Client’s Parent/Guardian, are responsible for ensuring that a referral is in place for all of your child’s visits. If you require additional therapy beyond the first \_\_\_\_\_\_\_ visits, your Therapist will submit a Benefit Extension form on your behalf. Your insurance company may take several days, and in some cases weeks, to process this request. Your therapy may need to be placed on hold if they are delayed in approving continued therapy for Your Child. |
| **PPO and Indemnity Standard Benefits:** | Primary Care Physician Referrals are not necessary. Your plan allows for \_\_\_\_\_\_\_\_\_ visits per year.  |
| **Changes to Insurance:** | If you’re insurance plan changes at any time during the course of your treatment you **MUST NOTIFY US IMMEDIATELY.** If Kids OT, Inc. is not notified you will be being billed for the entire amount.  |

I understand my insurance benefits as outlined above and agree to comply with payment as noted above. I understand that although Kids OT, Inc. will submit claims to my insurance company as a courtesy to me on my behalf this does not in any way relieve me of my financial responsibility for Your Child’ Occupational Therapy services.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Client Signature (or Parent if Client is a minor) |  | Date |

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Name of Insurance)**

**I, the undersigned hereby instruct the above named insurance company to pay by check made out to and mailed/deposited directly to:** Kids OT, Inc. for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered to my Child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(First and last name)

**THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, as required by my insurance policy.

I, the undersigned, understand that Kids OT, Inc. complies with HIPPA and my Child’s, Protected Health Information (PHI) which will be used as allowable by law in the treatment, billing and collection pertaining to my Child’s, care until my Child’s case is closed and full payment is received. I, the undersigned, also authorize the release of any information pertinent to my Child’s, case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me.

The authorization is in effect until 90 days from the date the last bill is collected. A photocopy of this Assignment shall be considered effective and valid as the original.

I, the undersigned, also authorize the release of any information pertinent to my Child’s, case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPPA guidelines.

|  |  |  |
| --- | --- | --- |
|  |  |   |
| Parent / Guardian / Client (Printed Name) |  | Date |
|  |  |  |
| Parent / Guardian / Client (Signature) |  | Staff Witness Signature |

**CLIENT PRIVACY PRACTICES**

Kids OT, Inc. feels the Privacy of Child’s personal information is an important principle.  Kids OT, Inc. is committed to collecting, using and disclosing personal information responsibly and only to the extent necessary to provide you and your Child with Occupational Therapy Services.  Kids OT, Inc. also tries to be as open and honest as possible about the way we handle your Child’s information.

Your Child’s personal information includes information that relates to personal characteristics (e.g. gender, age, home address, phone number, and family status), health (e.g. health/developmental history, health conditions/diagnoses, health services received) or activities and views (e.g. culture, community involvement).

Kids OT, Inc.’s primary purpose of collecting your Child’s personal information is to have a complete picture of their health and developmental history such as, Fine & Gross Motor, Language, Social/Emotional, Behavior and ADL’s (dressing/feeding/hygiene). This information helps us assess Your Child’s needs. Recommendations and treatment goals are established.  Your Child’s baseline scores can now help us identify changes occurring over time. This information is shared routinely with your written consent (e.g. Your Child’s school and/or insurance company).

Like most organizations, Kids OT, Inc. also collects, uses and discloses information for purposes related to Kids OT, Inc.’s primary purposes.  The most common examples are as follows:

1. To invoice clients for services received or to collect unpaid accounts
2. To advise clients and others of upcoming educational events
3. To ensure ongoing quality practice through peer chart audits
4. OT Students may inspect records &/or interview staff as part of their academic assignment.

As professionals, Kids OT, Inc. will report serious misconduct, incompetence or incapacity of other regulated practitioners, whether they belong to other organizations or our own.  Kids OT, Inc. believes that it should report information suggesting serious illegal behavior to the authorities.

Kids OT, Inc. is obligated to report suspected child neglect or abuse to the appropriate Family and Children’s Services (Children’s Aid).

You may have questions once Your Child begins services. Kids OT, Inc. can provide ongoing services for Your Child which may occur over a period of months or years for which Kids OT, Inc.’s developmental records for Your Child are helpful.

Kids OT, Inc. is required to retain Your Child’s therapy information for a minimum of seven years (or seven years after Your Child’s 18th birthday in the case of children) as per Insurance Guidelines for Providers.

Kids OT, Inc.’s Guidelines for Providers requires us To:

1. Kids OT, Inc. Keeps Paper information under supervision or secured in a locked or restricted area.
2. Kids OT, Inc.’s Electronic hardware is either under supervision or secured in a locked or restricted area at all times.
3. Kids OT, Inc..’s Passwords are used on all computers.
4. Kids OT, Inc.’s Paper information is transmitted through sealed, addressed envelopes by reputable companies.
5. Electronic information is anonymized and/or transmitted only with your informed consent.
6. All Kids OT, Inc..’s Staff are trained to collect, use and disclose personal information only as necessary to fulfill their duties and in accordance with our privacy policy.

Kids OT, Inc. need to retain Your Child’s personal information to ensure that we can answer any questions you might have about the services provided and for Kids OT, Inc.’s own accountability to external regulatory bodies.  We keep Your Child’s files for seven years (or seven years after age 18 for children).  Kids OT, Inc. will destroy paper files containing Your Child’s personal information by shredding and destroy electronic information by deleting it.

Kids OT, Inc. provides you the right to see Your Child’s personal information we hold.   Kids OT, Inc. staff will gladly help you identify what records we might have about Your Child within a scheduled appointment or during Your Child’s treatment time.  With only a few exceptions, Kids OT, Inc. staff will try to help you understand all information you do not understand.  If you believe there’s a mistake, you have the right to have it corrected.  This applies only to factual information and not to professional opinions Kids OT, Inc. therapist may have formed.

Kids OT, Inc. staff may ask you to provide documentation that Kids OT, Inc. files are wrong.  Kids OT, Inc. agrees that we made a mistake, we will make the correction and notify anyone to whom we sent this information.  If Kids OT, Inc. staff does not agree that we have made a mistake, we will still agree to include in Your Child’s file a brief statement from you on the point and we will forward that statement to anyone else who received the earlier information.

All formal complaints about Kids OT, Inc.’s privacy practices can be made in writing to Anita Poulin, OTR/L, Owner. She will acknowledge receipt of your complaint; ensure that it is investigated promptly and you will be provided with a formal decision along with the reasons in writing.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Parent / Guardian (Printed Name) |  | Client Printed Name |
|  |  |  |
| Parent / Guardian (Signature) |  | Date |

**DEVELOPMENTAL INFORMATION**

|  |  |
| --- | --- |
| Child’s Name: |  |

**Please check the column, which best describes your child. Please feel free to write any comments that you feel may be helpful. If more space is needed use the backside of this sheet.**

|  |  |  |
| --- | --- | --- |
| **PREGNANCY**  | **YES** | **NO** |
| 1. Did Biological Mother have any illnesses, injuries, fainting spells, bleeding, anemia, operations, drugs, medications or other difficulties during pregnancy?

COMMENTS |  |  |
| **DELIVERY** | **YES** | **NO** |
| 1. Was the pregnancy full term?

Birth Weight \_\_\_\_\_\_\_\_\_ lbs \_\_\_\_\_\_\_ ozs APGARS @ 1 minute \_\_\_\_\_\_\_\_\_\_\_@ 5 minute \_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 1. Was the pregnancy premature or unusual? Delivered at \_\_\_\_\_ weeks \_\_ Breach \_\_ Cesarean
 |  |  |
| 1. Was the labor abnormal?
 | Short | Long |
| 1. Were forceps or suction used? Give Details

COMMENTS |  |  |
| 1. Were medications given during delivery? What?

COMMENTS |  |  |
| **POST-NATAL** | **YES** | **NO** |
| 1. Was Your Child considered low birth weight
 |  |  |
| 1. Check which complications Your Child has experienced:

  *\_\_Jaundice \_\_Cyanosis \_\_Congenital \_\_Limpness \_\_Oxygen \_\_Transfusion \_\_Feeding difficulties*COMMENTS |  |  |
| 1. Check Which One Your Child Has Had:
 |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_\_ Meningitis  | \_\_\_\_ Mumps  | \_\_\_\_ Diabetes  | \_\_\_\_ Measles  |
| \_\_\_\_ Seizures  | \_\_\_\_ Physical Injuries  | \_\_\_\_ Polio  | \_\_\_\_ Convulsions  |
| \_\_\_\_ Chicken Pox  | \_\_\_\_ Tuberculosis  | \_\_\_\_ High Fevers  | \_\_\_\_ Scarlet Fever  |
| \_\_\_\_ Heart Problems  | \_\_\_\_ Whooping Cough  | \_\_\_\_ Excessive Vomiting | \_\_\_\_ Lung/Bronchial Difficulty |
| **DEVELOPMENTAL HISTORY** | **YES** | **NO** |
| 1. Were Your Child’s Developmental Milestones Age Appropriate
 |  |  |
| 1. What Areas of Your Child’s Development were Not Age Appropriate
 |  |  |
|  \_\_\_ Gross Motor  | \_\_\_ Fine Motor  | \_\_\_ Language  |
|  \_\_\_ Social Skills  | \_\_\_ Dressing  | \_\_\_ Behavioral |

|  |  |  |
| --- | --- | --- |
| **MEDICAL INFORMATION** | **YES** | **NO** |

|  |
| --- |
| 1. What Is Your Childs Diagnosis(s):\_
 |

|  |  |  |
| --- | --- | --- |
| 1. Currently does Your Child take for medication(s)?
 |  |  |
| If YES, What Are They and State Reason For Meds: |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **a.** | **b.** | **c.** | **d.** |

|  |  |  |
| --- | --- | --- |
| 1. Currently does Your Child have any allergies?

If YES, List What They Are: |  |  |

|  |  |  |
| --- | --- | --- |
| **Food:** | **Medical:** | **Seasonal:** |

|  |  |  |
| --- | --- | --- |
| **VISION INFORMATION** | **YES** | **NO** |
| 1. Does Your Child have VISION difficulties?
 |  |  |
| 1. When was your child’s last eye exam DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |  |  |
| 1. Does your child wear glasses ?
 |  |  |
| 1. What is the reason for Glasses ?

\_\_\_\_ Near Sighted \_\_\_\_\_\_ Far Sighted \_\_\_\_\_\_ Astigmatism \_\_\_\_ Lazy Eye \_\_\_\_ Other ? |  |  |
| **HEARING INFORMATION** | **YES** | **NO** |
| 1. Does Your Child have a history of Ear Infections?
 |  |  |
| 1. Were Tubes Placed? When/How Long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |  |  |
| 1. When was Your Child’s last HEARING exam DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RESULTS:
 |  |  |
| **ADL’s/SELF CARE INFORMATION** | **YES** | **NO** |

|  |  |  |
| --- | --- | --- |
| 1. Is Your Child able to DRESS Independently ?

If NO, Check What Your Child can do:\_\_\_\_ Tops On \_\_\_\_ Bottoms On \_\_\_\_Shoes On \_\_\_\_ Coats/Jackets On\_\_\_\_ Tops Off \_\_\_\_ Bottoms Off \_\_\_\_Shoes Off \_\_\_\_ Coats/Jackets Off |  |  |
| 1. Is Your Child able to FEED Independently ?

If NO, Check What Your Child can do:\_\_\_\_ Use Bottles \_\_\_\_ Use Sippy Cups \_\_\_\_ Use Cups \_\_\_\_ Use Straws \_\_\_\_Use Utensils |  |  |
| 1. Is Your Child able to BATH Independently ?

If NO, Check What Your Child can do: \_\_\_\_ Wash Hands \_\_\_\_ Wash Body \_\_\_\_Brush Teeth \_\_\_\_ Comb Hair \_\_\_\_ Dry Hands \_\_\_\_ Dry Body  |  |  |
| 1. Is Your Child able to TOILET Independently ?

If NO, Check What Your Child can do |  |  |

|  |
| --- |
| **PLEASE USE BACK FOR ADDITIONAL INFORMTION OR CONCERNS** |

Child Sensory Profile (4 to 10 years) by Winnie Dunn

**CODES**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| A = | ALWAYS | F = | FREQUENTLY | O = | OCCASIONALLY | S = | SELDOM | N = | NEVER |
| **A.** | **TACTILE PROCESSING** | **A** | **F** | **O** | **S** | **N** |
| 1. | Responds negatively to unexpected or loud noises (for example, cries or hides at noise from vacuum cleaner, dog barking, hair dryer) ? |  |  |  |  |  |
| 2. | Holds hands over ears to protect ears from sound ? |  |  |  |  |  |
| 3. | Has trouble completing tasks when the radio is on ? |  |  |  |  |  |
| 4. | Is distracted or has trouble functioning if there is a lot of noise around? |  |  |  |  |  |
| 5. | Can't work with background noise (for example, fan, refrigerator) ? |  |  |  |  |  |
| 6. | Appears to not hear what you say (for example, does not "tune-in" to what you say, appears to ignore you) ? |  |  |  |  |  |
| 7. | Doesn't respond when name is called but you know the child's hearing is OK? |  |  |  |  |  |
| 8. | Enjoys strange noises/seeks to make noise for noise's sake? |  |  |  |  |  |
| **B.** | **VISUAL PROCESSING** | **A** | **F** | **O** | **S** | **N** |
| 9. | Prefers to be in the dark? |  |  |  |  |  |
| 10. | Expresses discomfort with or avoids bright lights (for example, hides from sunlight through window in car) ? |  |  |  |  |  |
| 11. | Happy to be in the dark? |  |  |  |  |  |
| 12. | Becomes frustrated when trying to find objects in competing backgrounds (for example, a cluttered drawer) ? |  |  |  |  |  |
| 13. | Has difficulty putting puzzles together ( as compared to same age children) ? |  |  |  |  |  |
| 14. | Is bothered by bright lights after others have adapted to the light ? |  |  |  |  |  |
| 15. | Covers eyes or squints to protect our eyes from light? |  |  |  |  |  |
| 16. | Looks carefully or intensely ACTIV objects/people ( for example, stares) ? |  |  |  |  |  |
| 17. | Has a hard time finding objects in competing backgrounds ( for Example, shoes in messy room, favorite toy in the junk draw)  |  |  |  |  |  |
| **C.** | **VESTIBULAR PROCESSING** | **A** | **F** | **O** | **S** | **N** |
| 18. | Becomes Anxious or distressed when feet leave the ground ? |  |  |  |  |  |
| 19. | Dislikes activities where head is upside down (for example, somersaults, roughhousing) ? |  |  |  |  |  |
| 20. | Avoids playground equipment or moving toys ( for example, swing set, merry go round) ? |  |  |  |  |  |
| 21. | Dislikes riding in a car ? |  |  |  |  |  |
| 22. | Holds head up right, even when bending over or leaning (for example, maintains a rigid position/posture during activity) ? |  |  |  |  |  |
| 23. | Becomes disoriented after bending over a sink or table (for example, falls or gets dizzy) ? |  |  |  |  |  |
| 24. | Seeks all kinds of movement and this interferes with daily routines (for example, can’t sit still, fidgets) ? |  |  |  |  |  |
| 25. | Seeks out all kinds of movement activities (for example, being whirled around by adult, merry go round, playground equipment, moving toys) ? |  |  |  |  |  |
| 26. | Twirls/spins self frequently through the day ? |  |  |  |  |  |
| 27. | Rocks unconsciously (for example, while watching TV) ? |  |  |  |  |  |
| 28. | Rocks in desk/chair/on floor ? |  |  |  |  |  |
| **D.** | **TOUCH PROCESSING** | **A** | **F** | **O** | **S** | **N** |
| 29. | Avoids getting “messey” (for example, in paste, sand, finger paint, glue, tape) ? |  |  |  |  |  |
| 30. | Express is distress during grooming (for example, fights or cries during haircutting, face washing, fingernail cutting) ? |  |  |  |  |  |
| 31. | Prefers long-sleeved clothing when it is warm or short sleeves when it is cold? |  |  |  |  |  |
| 32. | Expresses discomfort at dental work or tooth brushing (for example, cries or fights) ? |  |  |  |  |  |
| 33. | He is sensitive to certain fabrics (for example, is particular about certain clothes or bedsheets) ? |  |  |  |  |  |
| 34. | Becomes irritated by shoes or socks? |  |  |  |  |  |
| 35. | Avoids going barefoot, especially in sand or grass? |  |  |  |  |  |
| 36. | Reacts emotionally or aggressively to touch? |  |  |  |  |  |
| 37. | Withdraws from splashing water? |  |  |  |  |  |
| 38. | Has difficulty standing in line or close to other people? |  |  |  |  |  |
| 39. | Rubs or scratches out a spot that has been touched ? |  |  |  |  |  |
| 40. | Touches people and objects to the point of irritating others have? |  |  |  |  |  |
| 41. | Displays unusual need for touching certain toys, surfaces, or textures (for example, constantly touching objects) ? |  |  |  |  |  |
| 42. | Decreased awareness of pain and temperature? |  |  |  |  |  |
| 43. | Doesn’t seem to notice when someone touches arm or back (for example, unaware) ? |  |  |  |  |  |
| 44. | Avoids wearing shoes, loves to be barefoot? |  |  |  |  |  |
| 45. | Touches people and objects? |  |  |  |  |  |
| 46. | Doesn’t seem to notice when face or hands are messy? |  |  |  |  |  |

**CODES TO USE**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| A = | ALWAYS | F = | FREQUENTLY | O = | OCCASIONALLY | S = | SELDOM | N = | NEVER |
| **E.** | **MULTISENSORY PROCESSING** | **A** | **F** | **O** | **S** | **N** |
| 47. | Gets lost easily (even in familiar places) ? |  |  |  |  |  |
| 48. | Has difficulty paying attention? |  |  |  |  |  |
| 49. | Looks away from tasks to notice all actions in room? |  |  |  |  |  |
| 50. | Seems oblivious within an active environment (for example, unaware of activity) ? |  |  |  |  |  |
| 51. | Hangs on people, furniture, or objects even in familiar situations? |  |  |  |  |  |
| 52. | Walks on toes? |  |  |  |  |  |
| 53. | Leaves clothing twisted on body? |  |  |  |  |  |
| **E.** | **ORAL SENSORY PROCESSING** | **A** | **F** | **O** | **S** | **N** |
| 54. | Gags easily with food textures or food utensils in mouth? |  |  |  |  |  |
| 55. | Avoids certain tastes or food smells that are typically part of children’s diets? |  |  |  |  |  |
| 56. | Will only eat certain tastes, list: |  |  |  |  |  |
| 57. | Limits self to particular food textures\ temperatures, list: |  |  |  |  |  |
| 58. | Picky eater, especially regarding food textures? |  |  |  |  |  |
| 59. | Routinely smells nonfood objects? |  |  |  |  |  |
| 60. | Shows strong preference for certain smells, list: |  |  |  |  |  |
| 61. | Shows strong preference for certain tastes, list: |  |  |  |  |  |
| 62. | Craves certain foods, list: |  |  |  |  |  |
| 63. | Seeks out certain tastes or smells, list: |  |  |  |  |  |
| 64. | Chews or licks on nonfood objects? |  |  |  |  |  |
| 65. | Mouths objects (for example, pencil, hands) ? |  |  |  |  |  |
| **G.** | **SENSORY PROCESSING RELATED TO ENDURANCE/TONE** | **A** | **F** | **O** | **S** | **N** |
| 66. | Moves stiffly? |  |  |  |  |  |
| 67. | Tires easily, especially when standing or holding particular body position? |  |  |  |  |  |
| 68. | Locks joints (for example, elbows, knees) for stability? |  |  |  |  |  |
| 69. | Seems to have weak muscles ? |  |  |  |  |  |
| 70. | Has a weak grasp ? |  |  |  |  |  |
| 71. | Can’t lift heavy objects (for example, weak in comparison to same age children) ? |  |  |  |  |  |
| 72. | Props to support self (even during activity) ? |  |  |  |  |  |
| 73. | Poor endurance\tires easily ? |  |  |  |  |  |
| 74. | Appears lethargic (for example, has no energy, is sluggish) ? |  |  |  |  |  |
| **H.** | **MODULATION RELATED TO BODY POSITION AND MOVEMENT**  | **A** | **F** | **O** | **S** | **N** |
| 75. | Seems accident prone ? |  |  |  |  |  |
| 76. | Hesitates going up or down curbs or steps (for example, is cautious, stops before moving) ? |  |  |  |  |  |
| 77. | Fears falling or Heights ? |  |  |  |  |  |
| 78. | Avoids climbing/jumping or avoids bumpy/uneven ground ? |  |  |  |  |  |
| 79. | Holds onto walls or banisters (for example, clings) ? |  |  |  |  |  |
| 80. | Takes excessive risks during play (for example, climbs high into a tree, jumps off tall furniture) ? |  |  |  |  |  |
| 81. | Takes movement or climbing risks during play that compromise personal safety ? |  |  |  |  |  |
| 82. | Turns whole body to look at you ? |  |  |  |  |  |
| 83. | Seeks opportunities to fall without regard to personal safety ? |  |  |  |  |  |
| 84. | Appears to enjoy falling ? |  |  |  |  |  |
| **I.** | **MODULATION OF MOVEMENT AFFECTING ACTIVITY LEVEL** | **A** | **F** | **O** | **S** | **N** |
| 85. | Spends most of the day in sedentary play (for example, does quiet things) ? |  |  |  |  |  |
| 86. | Prefers quiet, sedentary play (for example, watching TV, books, computers) ? |  |  |  |  |  |
| 87. | Seeks sedentary play options ? |  |  |  |  |  |
| 88. | Prefers sedentary activities ? |  |  |  |  |  |
| 89. | Becomes overly excitable during movement activity ? |  |  |  |  |  |
| 90. | “On the go” ? |  |  |  |  |  |
| 91. | Avoids quiet play activities ? |  |  |  |  |  |
| **J.** | **MODULATION OF SENSORY INPUT AFFECTING THE EMOTIONAL RESPONSES**  | **A** | **F** | **O** | **S** | **N** |
| 92. | Needs more protection from life than other children (for example, defenseless physically or emotionally) ? |  |  |  |  |  |
| 93. | Rigid rituals in personal hygiene ? |  |  |  |  |  |
| 94. | Is overly affectionate with others ? |  |  |  |  |  |
| 95. | Doesn’t perceive body language or facial expressions (for example, unable to interpret) ? |  |  |  |  |  |

**CODES TO USE**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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| K. | **MODULATION OF VISUALLY INPUT AFFECTING EMOTIONAL RESPONSES AND ACTIVITY LEVEL**  | **A** | **F** | **O** | **S** | **N** |
| 96. | Avoids eye contact ? |  |  |  |  |  |
| 97. | Stares intensely at objects or people ? |  |  |  |  |  |
| 98.  | Watches everyone when they move around the room ? |  |  |  |  |  |
| 99. | Doesn’t notice when people come into the room ? |  |  |  |  |  |
| **L.** | **EMOTIONAL/SOCIAL RESPONSES**  | **A** | **F** | **O** | **S** | **N** |
| 100. | Seems to have difficulty liking self (for example, low self esteem) ? |  |  |  |  |  |
| 101 | Has trouble “growing up” (for example, reacts immaturely to situations) ? |  |  |  |  |  |
| 102. | Is sensitive to criticisms ? |  |  |  |  |  |
| 103.  | Has definite fears (for example, fears are predictable) ? |  |  |  |  |  |
| 104.  | Seems anxious ? |  |  |  |  |  |
| 105.  | Displays excessive emotional outbursts when unsuccessful at a task ? |  |  |  |  |  |
| 106.  | Expresses feeling like a failure ? |  |  |  |  |  |
| 107.  | Is stubborn or uncooperative ? |  |  |  |  |  |
| 108.  | Has temper tantrums ? |  |  |  |  |  |
| 109.  | Poor frustration tolerance ? |  |  |  |  |  |
| 110.  | Cries easily ? |  |  |  |  |  |
| 111.  | Overly serious ? |  |  |  |  |  |
| 112.  | Has difficulty making friends (for example, does not interact or participate in group play)? |  |  |  |  |  |
| 113.  | Has nightmares ? |  |  |  |  |  |
| 114.  | Has fears that interfere with daily routine ? |  |  |  |  |  |
| 115.  | Doesn’t have a sense of humor ? |  |  |  |  |  |
| 116.  | Doesn’t express emotions ? |  |  |  |  |  |
| **M.** | **BEHAVIORAL OUTCOMES SENSORY PROCESSING**  | **A** | **F** | **O** | **S** | **N** |
| 117.  | Talks self through tasks ? |  |  |  |  |  |
| 118.  | Writing is illegible ? |  |  |  |  |  |
| 119.  | Has trouble staying between the lines when coloring or when writing ? |  |  |  |  |  |
| 120.  | Uses inefficient ways of doing things (for example, waste time, moves slowly, does things a harder way than is needed) ? |  |  |  |  |  |
| 121.  | Has difficulty tolerating changes in plans and expectations ? |  |  |  |  |  |
| 122.  | Has difficulty tolerating changes in routines ? |  |  |  |  |  |
| **N.** | **ITEMS INDICATING THRESHOLDS FOR RESPONSE**  | **A** | **F** | **O** | **S** | **N** |
| 123.  | Jumps from one activity to another so that it interferes with play ? |  |  |  |  |  |
| 124.  | Deliberately smells objects ? |  |  |  |  |  |
| 125.  | Does not seem to smell strong odors time ? |  |  |  |  |  |

**ADDITIONAL INFORMATION:**