RED DOOR
PEDIATRIC THERAPY

www.reddoorpediatric.com


Bismarck Location
2625 N 19th Street
Bismarck, North Dakota 58503

Minot Location
2080 36th Ave SW Suite 110
Minot, ND 58701

Grand Forks Location
2820 19ths Ave S
Grand Forks, ND 58201

**Phone: 701-222-3175**
**Fax: 701-222-3186**


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## Red Door General Intake

Our evaluation of you will depend on information about your past history. Fill out this form as completely as possible and bring with you the day of the evaluation. If you have questions regarding any items, put a checkmark in the left margin and we can discuss them when you come for your appointment.

Today's date:_____

Person completing form (if other than patient; first/last name):_____

Relationship to patient (if applicable):_____

**IDENTIFICATION:**
Patient's full name: _____ Birthdate:_____ Sex: _____ Age: _____

Address: _____

City: _____ State: _____ Zip:_____

| |
|---|
| Cell phone #: |
| Home phone # (if different than cell phone #s): |
| Place of Employment: |
| Occupation: |
| Work phone #: |
| Email: |
| Preferred method of contact (phone call or email): |
| Emergency contact (name and phone number): |
| Relationship to patient: |

**PHYSICIAN INFORMATION:**
Patient's primary doctor:_____

**MEDICAL HISTORY:**
Is the patient now under the care of a doctor (including orthodontist & dentist)? _____

Why?_____

_____

_____

Does the patient currently carry any medical diagnoses?_____ If yes, please indicate diagnoses, medical professional who made the diagnoses, and date of diagnoses if known:

_____

_____

_____

Is the patient taking medication (yes/no)?_____

Type?_____

Is the patient taking supplements (yes/no)?_____

Type?_____

At what age did any of the following occur? Indicate severity.

| | Age | Mild | Mod | Severe | | Age | Mild | Mod | Severe |
|---|---|---|---|---|---|---|---|---|---|
| Adenoidectomy | | | | | Muscle disorder | | | | |
| Asthma | | | | | Ear tubes | | | | |
| Chronic colds | | | | | Nerve disorder | | | | |
| Craniofacial problems | | | | | Pneumonia | | | | |
| Headaches | | | | | Respiratory infections | | | | |
| History of head injury | | | | | Strep throat | | | | |
| Heart murmur | | | | | Seizures | | | | |
| Immune deficiency syndrome | | | | | Tonsillectomy | | | | |
| Influenza | | | | | | | | | |

Other:

Known allergies:

_____

Surgical history:

_____

_____

_____

_____

Is the patient currently seen by a Chiropractor? _____

When was the last time the patient has been to the dentist?_____ Any concerns reported?_____

If yes, explain:_____

_____

When was the last time the patient has been to the eye doctor?_____Any concerns reported?_____

If yes, explain:_____Does the patient currently wear glasses?_____

_____

When was the last time the patient had a hearing test?_____ Any concerns reported?_____

If yes, explain:_____

_____

**SERVICE HISTORY:**
Describe any speech, language, hearing, occupational/physical therapy, psychological, or special education services that the patient has previously received:

_____

_____

_____

**EDUCATIONAL HISTORY:**
Highest completed grade level:_____

Degrees held:_____

**ADDITIONAL INFORMATION:**

Current hobbies/interests:

_____

_____

Primary concerns and reasons for seeking an evaluation:

_____

_____

_____

Please add any additional information you want us to know:

_____

_____

_____

How did you hear about Red Door Pediatric Therapy?

_____

**CONFIDENTIALITY:**

As mandated by law, we are required to report any suspected child molestation, neglect and emotional or physical abuse to protect the children involved. As an entity, we do not disclose filing events.

_____Initials _____Date

Signature of person filling out form:_____Date:_____

# Insurance Information

## Primary coverage:

| | |
|---|---|
| Patient name: | |
| Policyholder: | |
| Policy ID number: | |
| Group number: | |
| Insurance provider number: | |
| Insurance Company Name:<br>Address:<br>Phone Number: | |

## Secondary coverage if applicable:

| | |
|---|---|
| Patient name: | |
| Policyholder: | |
| Policy ID number: | |
| Group number: | |
| Insurance provider number: | |
| Insurance Company Name:<br>Address:<br>Phone Number: | |

I hereby acknowledge that the information provided above is accurate and current:

Signature_____ Date:_____

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# Attendance Policy

Welcome to Red Door Pediatric Therapy!

Several factors go into scheduling your evaluation and subsequent appointments including therapy recommendations, insurance approval/parameters, and convenience/availability of preferred times.

Maintaining a consistent therapy schedule is critical to achieving progress toward short and long-term objectives. Because of the demand for therapy services and to ensure positive outcomes on your plan of care, we would like to highlight the following attendance policy:

**Initial Evaluation:**
We understand that conflicts arise, but if you cancel or no show two consecutive initial evaluations, we do not allow you to reschedule an evaluation for a 6-month time frame.

**Permanent Schedule:**
If you have a time slot on our permanent schedule, those sessions are considered standing appointments. We require a minimum attendance rate of 60% over a 6 month period.

**Call-In Schedule:**
Once you have called in and scheduled in an available time slot, those sessions are considered standing appointments. We require a minimum attendance rate of 60% of scheduled appointments. A minimum of 2 sessions per month are required in order to remain on the call-in list.

We understand that sometimes appointments have to be canceled due to illness, vacation, outside events, and unexpected circumstances. In these instances, we do our best to reschedule to a different time to allow you to maintain a consistent schedule and receive the recommended number of visits per week.

If we find that you are unable to adhere to our scheduling policy, we will work together to determine the best available schedule that works for you as well as Red Door Pediatric Therapy. If we are unable to provide consistent therapy services due to lack of attendance, we will discharge you from therapy for a 6-month time frame. After that, we encourage you to initiate services at a time when attendance and progress toward the plan of care can be a priority.

We appreciate your commitment and can’t wait to get started!