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

Red Door General Intake

Our evaluation of your child will depend on information about his/her 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 (first/last name):_____Relationship to child:_____

If you are not the child's current legal guardian, please list the legal guardian:_____

IDENTIFICATION:

Child's full name: _____Birthdate:_____ Sex: _____ Age: _____

Who does the child live with? _____

Address of child's primary residence: _____

City: _____State: _____Zip: _____

Mother	*Father*
Name:	Name:
Age: DOB:	Age: DOB:
Cell phone #:	Cell phone #
Home phone # (if different than cell phone #s):	
Place of Employment:	Place of Employment:
Occupation:	Occupation:
Work phone #:	Work phone #:
Email:	Email:
Preferred method of contact (phone call or email):	
Emergency contact (name and phone number):	
Relationship to child:	

Siblings:

Name	Age	Sex	Grade	Speech/language, OT, medical conditions:

PHYSICIAN INFORMATION:

Child's Primary Doctor:_____

PREGNANCY/BIRTH HISTORY:

Which pregnancy was this child?_____ Were there any illness, diseases, or accidents that occurred during pregnancy?_____

_____

Was there in utero exposure to drugs or alcohol? _____

Age of mother at child's birth:_____ Age of father at child's birth:_____

Length of pregnancy:	Type of delivery:
Birth weight:	Apgar scores:
Length of labor:	Was labor difficult?

Was medical intervention needed during labor/delivery (if yes, please explain (ex. induction, forceps, epidural, blood transfusion, etc.)?

_____

Were there any bruises, scars, or abnormalities to the child's head?

_____

Did the child require oxygen? yes / no Was child "blue"? yes / no Was the child jaundice? yes / no

Were there any problems immediately following birth or during the first two weeks of the child's life (ex. NICU, nursing, swallowing, sucking, feeding, sleeping, etc.)? If so, describe:

_____

_____

DEVELOPMENTAL HISTORY:

At what age did the child develop the following skills:

Rolled over alone:	Sat alone:	Crawled:
Stood alone:	Walked unaided:	Fed self with spoon:
Bladder trained:	Bowel trained:	Consumed solid foods:
First word:	First phrase:	Conversation:

Do you have:	YES	NO
Communication concerns		
Fine motor concerns		
Gross motor concerns		
Sensory concerns		

Please describe the child's overall social behavior? _____

The child prefers to: Play alone_____ Parallel play_____ Play with others_____
(*parallel play is to play alongside other children, but not with other children)

MEDICAL HISTORY:

Is the child now under the care of a doctor?_____Why?_____

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

_____

Is he/she taking medication?_____ Type?_____

Is he/she taking supplements?_____ Type? _____

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

	Age	Mild	Mod	Severe		Age	Mild	Mod	Severe
Adenoidectomy					Influenza				
Chronic colds					PE tubes				
Cross-eyed					Pneumonia				
Croup					Strep throat				
Earaches/ear infections					Seizures				
Headaches					Tonsillectomy				
Heart murmur					Whooping cough				
Other:									

Known allergies:_____

Has the child ever had an extremely long, high fever?_____ If yes, please explain: _____

_____

Has the child ever fallen or had a blow to the head?_____ If so, did he/she lose consciousness?_____

Did it cause a concussion?____ Did it cause nausea?_____ Vomiting?_____ Did any of the above require hospitalization?_____

Surgical history:_____

_____

Is the child currently seen by a Chiropractor? _____
When was the last time the child has been to the dentist?_____ Any concerns reported?_____
If yes, explain:_____
When was the last time the child has been to the eye doctor?_____Any concerns reported?_____
If yes, explain:_____Does your child currently wear glasses?_____
When was the last time the child has had his/her hearing checked?_____ Any concerns reported?_____
If yes, explain:_____

Check these as they apply to your child.

	Yes	No	Explain:
Eating problems			
Sleeping problems			
Toilet training problems			
Difficulty concentrating			
Difficulty staying with an activity			
Requires a lot of discipline			
Underactive			
Overactive			
Cries a lot			
Sensitive/Emotional			
Likes rough play			
Irritable			
Difficulty getting along with children			
Difficulty getting along with adults			
Difficulty making friends			
Has frequent tantrums			
Frequently fearful			
Gets stuck on topics			
Obsessions/compulsions			
Avoids eye contact			
Has limited interests			
Confused by gestures			
Misinterprets social situations			

Has or uses an alternative communication mode (e.g. sign language, pictures, device)			
Falls, trips often, or is overall “clumsy”			
Walks on tiptoes often or feet turn inward with walking			
Difficulty with coordination, running, or jumping tasks compared to peers			

Does the child separate from his/her caregivers without crying or fussing?_____

Are you concerned with your child’s behavior?_____ If so, what is most concerning to you?

_____

_____

How do you deal with negative behaviors or what discipline method works best?

_____

Favorite play or motivating activities for your child?_____

_____

EDUCATIONAL HISTORY:

Does the child attend daycare?_____ Where?_____

How many hours per week?_____Does the child attend school?_____

Where?_____Is your child on an IFSP or IEP?_____

Grade?_____ What are his/her average grades:_____ Best subjects:_____

Challenging subjects:_____ Is the child frequently absent from school?_____

If so, why?_____

How does the child feel about school or his/her

teacher?_____

Has anyone ever thought he/she has learning difficulties (ex., dyslexia)?

_____

Does the child receive any special instructions for reading (e.g. Title 1, etc.). _____

Describe any speech, language, hearing, occupational/physical therapy, psychological, or special education services that your child is currently enrolled in. How often does your child attend this service?

_____

_____

_____

ADDITIONAL INFORMATION:

What are your 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? _____

DIAPER AND TOILETING PROCEDURES:

When necessary, Red Door Pediatric Therapy staff may change a child's diaper and/or provide toileting assistance under the following conditions:

-consent has been signed (see below)

-it is understood that no application of creams, powders, or ointments will be administered

-it is understood that parents/caregivers are responsible for providing diapers, wipes, and a change of clothes in the event of an accident

Consent for Diaper Changing:

I, _____, give permission for Red Door Pediatric Therapy staff to change
(print parent/guardian name)

_____'s diaper and/or assist with toileting as necessary. I understand and agree
(print child's name)
to the terms listed above. I also understand that I may revoke this permission at any time.

Parent/guardian's signature:_____

Date: _____

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:

Child name:	
Policyholder:	
Policy ID number:	
Group number:	
Insurance provider number:	
Insurance Company Name: Address: Phone Number:	

Secondary coverage if applicable:

Child name:	
Policyholder:	
Policy ID number:	
Group number:	
Insurance provider number:	
Insurance Company Name: Address: 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 in to scheduling your child's evaluations and subsequent appointments including therapy recommendations, insurance approval/parameters, and convenience/availability of preferred times for your family.

Maintaining a consistent therapy schedule is critical to achieve progress toward short and long-term objectives. Because of the demand for therapy services and to ensure positive outcomes on your child's 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 your child has 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 your child 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 cancelled due to illness, vacation, outside events, and unexpected circumstances. In these instances, we do our best to reschedule to a different time to allow your child 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 your family as well as Red Door Pediatric Therapy. If we are unable to provide consistent therapy services due to lack of attendance, we will discharge your child 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!