Sensory Pathways 4 Kids

Date: _____

Please complete the form before submitting.

Child Full Name _____ Nick Name: _____ DOB:_____ Age:____ Sex _____

Parent Full Name (a)_____Parent Full Name (b)_____

Child lives with: _____ Home Phone: _____

Insured Name: _____ Insured DOB: _____

Insurance: _____ ID#_____ Group # _____

2nd Insurance: _____ ID# _____ Group # _____

Parent Address (a) _____
Street Apt# City State Zip

Email: _____Work#_____ Cell#_____

Parent Address (b) if different: _____
Street Apt# City State Zip

Email: _____ Work#_____ Cell #_____

Child's Physician Name:_____Practice Name:_____

Phone # _____ Fax # _____

Referred by:_____ Phone # _____

Child's School _____ Grade: _____ Teacher_____

Diagnosis: _____ Medications: _____

Comments:

_____

_____

_____

Intake Date: _____ Time: _____ Therapist_____

Eval Date: _____ Time: _____ Therapist_____ Location_____

Notes:

- ☐ Called/emailed Date_____
- ☐ Bene Requested
- ☐ Bene Received
- ☐ Web PT
- ☐ Prescription
- ☐ Welcome Letter