



Intake Packet

Directions: Please fill out this intake form in its entirety. Once completed, please email to nicoleslp10@aol.com or fax to 732-866-4344. Please include the front and back of your insurance card and a script from your doctor.

Child's Information

First Name:	
Last Name:	
Gender:	
Date Of Birth:	
Address:	
Home Phone Number:	
Allergies/Dietary Restrictions:	
Vaccines up to date:	

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Parent/Guardian Information

First Name:	
Last Name:	
Date of Birth:	
Address:	
Home Phone Number:	
Cell Number:	
Work Number:	
Email:	
Occupation:	
Relationship to child:	

First Name:	
Last Name:	

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Date of Birth:	
Address:	
Home Phone Number:	
Cell Phone Number:	
Work Phone Number:	
Email:	
Occupation:	
Relationship to child:	

Parent Marital Status

Are the parents of this child	Married _____ Divorced _____
If divorced are there any special custodial arrangements we need to be aware of? (Example: one parent has full custodial rights; both parents need to be present at evaluation etc.)	YES _____ NO _____

Primary Insurance Information

Name of primary insurance holder:	
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Relation to child:	
Policy holder date of birth:	
Employer:	
Employer work number:	
Primary Insurance:	
ID number:	
Group number:	
Occupation:	
Relationship to child:	

Secondary Insurance (If applicable)

Name of primary insurance holder:	
Relation to child: Policy holder date of birth:	
Employer:	

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Employer work number:	
Primary insurance:	
ID number:	
Group number:	
Occupation:	
Relationship to child:	

Diagnosis

Please list your child's diagnosis:	
Date diagnosis was first given:	
Doctor's name that first gave you the diagnosis:	

What services are you looking for (check all that apply)

_____ Occupational therapy

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_____ Speech therapy

_____ Physical Therapy

_____ ABA/behavioral therapy

_____ Social Skills groups

At what age did your child:

Sit:	
Crawl:	
Walk:	
Speak:	

Is your child:

Verbal (if no please explain how the communicate their wants and needs)	
Behavioral (please explain any behavioral concerns)	



What are the presenting problems that are most concerning to you? Why are you seeking an evaluation?

Please let us know how you heard of us?

Social media

Referral from doctor (please specify which doctor) _____

Referral from friend

Internet search

Private Insurance

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____ Other

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