Spot On Therapy Group

Spot On Therapy Group, LLC
Client Contact Information

Today's Date: _____

Client Name: _____ DOB: _____

Sex: _____

Address: _____ City: _____

State _____ Zip _____ Email Address: _____

Home Phone: _____ Cell Phone: _____

Referred by:(name and title) _____

Primary Care Physician _____

Name of Practice _____

Address _____ Phone _____

If client is a child, parent/guardian, please complete the following:

Mother's Name: _____ Occupation: _____

Address (if different from above) _____

Phone (if different from above): Home Phone _____ Cell _____

Work Phone: _____ Employer _____

Father's Name: _____ Occupation: _____

Address (if different from above) _____

Phone (if different from above): Home Phone _____ Cell _____

Work Phone: _____ Employer _____

In case of emergency contact:

Name _____ Phone _____

Relationship to client _____

Insurance/Payment Information

Person responsible for payment of services: _____

Insurance Company _____

Primary Insured's Name _____ DOB _____

Insured's ID Number _____ Insured's Group Number _____

Relationship to client _____ Primary Insured's Social Security #_____

Is your child enrolled in Medicaid (secondary insurance)?

Policy/ID# _____ **Please provide us with copy of card.**

If my insurance policy/plan limits the number of therapy visits allowed, I understand that I am responsible for keeping track of the number of used or remaining visits. If the client is seen beyond the approved number of visits, I understand that I am responsible for all charges that exceed the allowed number of visits approved by my insurance company.

Initials _____ Date _____

Spot On Therapy Group

RELEASE OF INFORMATION AGREEMENT

Client Full Name _____ Date of Birth _____

I request and authorize Spot On Therapy Group, LLC to release/exchange healthcare information of the client listed above to:

Name _____
Phone _____ Fax _____
Business/Affiliation with Client _____
Address _____
City/State _____ Zip _____
This authorization applies to the following information (please be specific)
_____
_____
This authorization expires on _____

Name _____
Phone _____ Fax _____
Business/Affiliation with Client _____
Address _____
City/State _____ Zip _____
This authorization applies to the following information (please be specific)
_____
_____
This authorization expires on _____

Name _____
Phone _____ Fax _____
Business/Affiliation with Client _____
Address _____
City/State _____ Zip _____
This authorization applies to the following information (please be specific)
_____
_____
This authorization expires on _____

_____ Parent/Guardian Printed Name

_____ Client Name

_____ Parent/Guardian Signature

_____ Date

ATTENDANCE, CANCELLATIONS, AND DISCHARGE POLICIES (Rev 9/1/24)

Regular and consistent attendance is required in order to show treatment progress and to maintain your scheduled appointment time.

Cancellations must be made with at least 24 hours' notice, or a $50.00 fee will be charged. This applies to clinic, telehealth, and community based appointments. We understand that due to illness or other unexpected events it may be necessary for you to occasionally cancel a therapy appointment. Please call your therapist or the office manager and leave a message if you reach voicemail. Make up sessions are encouraged.

MISSED OR NO SHOW APPOINTMENTS : A fee of $50.00 will be charged if the 24-hour notice is not given; this fee is charged in an effort to deter unnecessary missed appointments. This fee cannot be billed to your insurance company and will be due and payable prior to your next scheduled treatment session. *Two no show/no call appointments **will** result in removal from the therapy schedule.*

TARDINESS: You have chosen a specific day/time for your therapy appointment. If you arrive late, the treating therapist will determine if there is enough time to proceed with the session, and the session will conclude at the regularly scheduled time. *We reserve the right to remove you/your child from the schedule if you do not consistently arrive at your scheduled appointment time.*

Being absent or tardy both impedes the therapy process and financially impacts our staff and Spot On Therapy Group. We also have a long waitlist of families who need therapy services. If you are faced with a scheduling challenge, please see the front desk in order to find a more preferable therapy time.

DISCHARGE POLICY It is the policy of Spot On Therapy Group to discharge clients who meet one of the following criteria: no longer demonstrates need for intervention, does not appear to benefit from continued services, is not meeting financial responsibilities to Spot On Therapy Group, does not meet the required attendance (as outlined above), is requested by the parent/caregiver, or at the discretion of the agency.

By signing below, I acknowledge that I have fully read and understand the Spot On Therapy Group Attendance, Cancellations, and Discharge Policy (updated 1/5/23).

Client Full Name _____ Date_____

Client/Parent/Guardian Printed Name _____

Initials By initialing, you give Spot On Therapy Group permission to send you text and/or email appointment reminders. Please indicate what phone number or email to use for reminders. _____

Client/Parent/Guardian Signature _____

Spot On Therapy Group
4840 Waller Rd. Suite 200
Richmond, Virginia 23230
NPI 1508249632 Phone: 804 893-5010

Telehealth Consent Form

Child's name: _____ **DOB:** _____

Parent/Legal Guardian's Name: _____

Check all that apply now or in the future.

Visit type(s): ☐ **OT** ☐ **Speech** ☐ **PT** ☐ **Neurofeedback**

Telemedicine involves the use of electronic communications to enable health care providers at a different location to engage in live two-way video conferencing for the purpose of providing speech/OT/PT services. I understand that electronic systems used during the Telemedicine session will incorporate network and software security protocols to protect the confidentiality of patient identification and will include measures to safeguard the data (e.g. password protected screensavers, encrypted data files) and to ensure its integrity against intentional or unintentional corruption.

1. **Confidentiality:** I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent as outlined by HIPAA (Health Insurance Portability and Accountability Act).
2. **Patient Rights**: I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my child's care at any time, without affecting his/her right to future care or treatment. I will be informed of any other people who are present at either end of the telehealth encounter and have the right to exclude anyone from either location. All confidentiality protections required by law or regulation will apply to my care.
3. **Medical Records**: A contact note will be written during/after your telehealth appointment and will be accessible to both the practitioner and the patient, and consistent with all established laws and regulations governing patient healthcare records.

I hold Spot On Therapy Group harmless for interruptions, unauthorized access, technical difficulties, and call termination during our telehealth video calls. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the video/audio connections are not adequate for my situation. It is my preference and/or need for my OT/ST/PT provider to deliver services via telehealth either for medical-health/safety reasons until we are able to meet face-to-face (if related to COVID-19) or parent preference if always covered by insurance.

I understand and consent to participate in Telehealth Services for Speech/OT/PT therapy or Neurofeedback.

_____ _____

Parent/Guardian Signature Date

FINANCIAL POLICY AGREEMENT

Client Full Name: _____ Date: _____

If you have Health Insurance, we want you to receive your full benefit. Our office team can assist you in completing your insurance forms and verifying benefits/coverage. If Spot On Therapy Group is in network with your insurance provider, you are responsible for your deductible and the co-payment or coinsurance(the portion insurance does not cover) at the time services are provided. Please note, the portion of the total fees covered by your insurance may be different than the amount quoted on the day of service. You are encouraged to verify your insurance policy benefits. You are responsible for any outstanding balance after insurance has been applied.

By initialing, I understand that I am responsible for the payment of a one-time $100.00 Educational Consultation fee for the initial evaluation. This fee cannot be submitted to insurance and is the client's responsibility. Initial _____

PAYMENT FOR SERVICES: Spot On Therapy Group accepts cash, checks, Visa, MasterCard, Discover, American Express and PayPal.

CONTRACTUAL AGREEMENT:

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY AND SIGN BELOW

I understand all client co-payments are due payable at the time services are rendered. I authorize payment directly to Spot On Therapy Group for the benefit otherwise payable to me under the terms of any insurance. I understand I am financially responsible for all charges arising from the treatment of the above named client and any insurance payments will be credited to the account. In the event the bank returns any check given in payment on this account, unpaid for any reason, a $35.00 charge will be added to the account balance each time a check is returned. If all charges are not paid in full within sixty (60) days from the date of service, I agree to pay the service charge of eighteen percent (18%) per month with a twenty-one percent (21%) annual interest on the unpaid balance. If this account is referred to an attorney for collection, I agree to pay all costs of collection, including, but not limited to attorney's fees and all court costs.

By signing below, I acknowledge that I have fully read and understand the Spot On Therapy Group Financial Policy Agreement.

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____ Date _____

Spot On Therapy Group

CLINIC ETIQUETTE

We welcome you to Spot On Therapy Group. We are honored that you have chosen our clinic to meet the needs of your child and your family. We hope that you are comfortable here and always feel welcome. In order to make Spot On Therapy Group a comfortable and safe place for all of our families and our staff, we ask that families observe appropriate clinic etiquette. Please read and become familiar with the following expectations. If you have any concerns regarding policies, please discuss it with the front desk staff.

1. Upon arrival, check in at the front desk.
2. Supervise your children at all times. Spot On Therapy Group staff is not responsible for monitoring children in the waiting room or other common areas. Closely monitor your children's behavior in the waiting room to ensure that they are playing safely and that they are playing appropriately with other children. Do not allow children to climb on, jump from, or over the waiting room furniture or toys. Help your children clean up including replacing books and toys to designated areas and throwing away any trash.
3. Accompany all younger children and those needing assistance or supervision to the restroom; this includes using the restroom for hand washing.
4. If you have children in diapers or pull-ups, bring a diaper bag to therapy and be prepared to change your child if necessary. All children that are not fully potty-trained will be expected to wear a diaper or pull-up during sessions as to ensure a clean and healthy environment (OSHA regulation).
5. Do not allow your children to enter the door from the lobby to the treatment area unaccompanied.
6. For safety reasons, do not allow your children to play with any doors, especially those leading to the therapy treatment area.
7. If you have permission to observe your child's treatment session, remain in the same room as your child and their therapist. In order to protect the confidentiality of all children in our clinic, we ask that if you need to leave the treatment room for any reason, you return to the waiting room and wait for the session to end. If your child and the therapist leave the room, either follow them or wait for them in the waiting room.
8. Refrain from talking on your cell phone in the waiting area and other common areas. Keep cell phone use to a minimum and place phones on vibrate or silent.
9. Do not ask therapists about other clients or families at the clinic.
10. Be respectful of the "end of session" time. Your therapist has approximately 5 minutes to talk to you about the session. Most often, there is another family waiting to begin therapy. If you need additional time to discuss a concern, ask questions or problem-solve treatment activities, let your therapist know prior to the start of your child's session, and they will make time to discuss your concern prior to the end of the session.
11. Due to the number of children we treat with allergies and restricted diets, we ask that foods containing any nuts or other common allergens not be brought into the clinic, including the waiting area. We ask that all food items remain at the tables provided in the waiting area or at the outdoor picnic area and that all food trash be disposed of properly. Please wipe tables after use. Wipes are available in the bathroom. Inform your therapist if your child has severe allergies. If your child requires a medication due to allergen exposure, you will be required to remain on site in the event that his/her medication needs to be administered.
12. We value your commitment to your child's attendance in therapy; however, for the protection of all of the children and staff, we kindly request that you do not bring your child to therapy if they or any other household members are sick or have any contagious illnesses (e.g. vomiting, diarrhea, fever, strep throat, pink eye(conjunctivitis), head lice, scabies or ringworm). Make sure that the symptoms have been resolved for at least 24 hours prior to returning to therapy.

By signing below, I acknowledge that I have fully read and understand the Spot On Therapy Group Clinic Etiquette Policy.

Client Full Name _____ Date _____

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____

Spot On Therapy Group

Permission for Parent/Guardian to Leave Spot On Therapy Group Premises During Treatment

By signing this form, I, _____, acknowledge that while my child, _____ receives therapy, I may leave Spot On Therapy Group physical premises. However, I agree that I will not travel more than five miles from the therapy site and will return **10 minutes** prior to the end of the session. I understand that I will not leave the premises if I do not have a mobile phone for immediate contact. I understand that the ability to continue to leave the premises while my child is in therapy is at the discretion of Spot On Therapy Group and/or the treating therapist and this privilege may be revoked at any time.

By leaving Spot On Therapy Group, I give consent and permission for Spot On Therapy Group to seek medical treatment or transportation for medical treatment in the event my child is injured or needs immediate medical assistance.

I understand that failure to comply with the requirements above will result in immediate revocation of this privilege and, potentially, revocation of my child's regularly scheduled therapy time. By leaving the physical premises, I hereby release Spot On Therapy Group, LLC and any agents and/or assignees from any and all claims for injuries or damages related to my leaving the premises during my child's therapy appointment.

Child's Full Name _____

Hospital of Choice _____

Parent/Guardian Name (please print) _____

Parent/Guardian Signature _____ Date _____

Emergency Contact / Cell Number _____

PRIVACY PRACTICES POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinicians or other treatment team members. *We may disclose PHI to any other consultant only with your specific written authorization.*

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support certain business activities including, but not limited to, sharing your PHI with third parties that perform various business activities (e.g., billing or typing services) only if we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. Your PHI may be disclosed via email, if you have given written permission, for appointment reminders, and to provide information about treatment alternatives or other health-related benefits and services.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose information to family members that are directly involved in you or your child's treatment *with your verbal permission.*

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI that we maintain about you. To exercise any of these rights, please submit your request in writing:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask for amendment of the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice. **Please notify Spot On Therapy Group, LLC if you would like a copy. Please also check the appropriate box on the signature page, indicating you received a copy of this notice.

Spot On Therapy Group, LLC
Written Acknowledgement Form

By signing this form, I acknowledge and agree as follows:

I have been given the opportunity to read Spot On Therapy Group's Notice of Privacy Practices policy statement prior to signing this acknowledgement form.

The Privacy Practices policy statement includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for Spot On Therapy Group, LLC to treat me and/or my child and to obtain payment for that treatment.

_____ By initialing, I indicate that I ***would*** like a printed copy of Spot On Therapy Group's Notice of Privacy Practices Policy.

_____ _____
Name of Client Date

_____ _____
Printed Name of Parent/Guardian Relationship to Client

_____
Signature of Parent/Guardian

Spot On Therapy Group

Permission to Discuss Treatment Session in Waiting Area

Communication with parents/family members is a critical step to success of the therapy process. Following therapy, your child will be brought to the waiting room by his/her therapist. The therapist will assist your child in transitioning, provide a *brief* report on the treatment session, make recommendations, and answer questions.

It is not always possible to find an unoccupied room to provide a *confidential* report to parents/family members, and this additional transition is also very difficult for many of the children.

By initialing below, you indicate whether you *opt in or opt out* of the treatment session report *in the waiting area*. If you opt out, your therapist will coordinate an alternate method of communicating session progress and recommendations.

_____ (initials) *I **OPT IN,** giving permission for the therapist to provide a report of my child's treatment session in the waiting area.*

_____ (initials) ***OPT OUT** of the therapist providing a report of my child's treatment session in the waiting area*. My therapist will be notified and will coordinate an alternate means of communication about session progress and recommendations.

All parents/legal guardians sign below to indicate they have read this policy.

_____ Date _____

Child's Name (print)

_____

Print Parent/Legal Guardian Name

_____

Signature

Spot On Therapy Group

SPOT ON THERAPY GROUP, LLC

CLIENT/CHILD BACKGROUND INFORMATION

IDENTIFYING INFORMATION Date: _____

Child's Full Name: _____ Age: _____ Birth Date: _____ Sex: _____

Preferred Name/Nickname:_____

Mother's Name:_____ Father's Name:_____

Address: _____ Address: _____

_____ _____

Daytime Phone: _____ Daytime Phone: _____

Cell Phone: _____ Cell Phone: _____

E-mail: _____ E-mail: _____

Primary Physician's Name: _____ Physician's Phone: _____

The child lives with: ☐ Birth Parents ☐ Adoptive Parents ☐ Foster Parents

☐ One Parent ☐ Siblings ☐ Parent and Step-parent

Other: _____

REFERRING INFORMATION

Who referred this child to our clinic? _____

Reason for referral:

_____

May we have your permission to thank this person for the referral? ☐ Yes ☐ No

What are <u>your</u> primary concerns and/or goals regarding your child?

_____

_____

At what age did you begin to have these concerns? _____

In what settings does your child struggle? (i.e. home, school, store, etc.)

In what settings does your child do well? (i.e. home, school, store, etc.)

What are your child's strengths?

How would you describe your child?

Does your child have a history of physical aggression toward others?

Currently ☐ Previously ☐

Please describe the behavior (i.e., biting, hitting, throwing furniture, etc.)

MEDICAL HISTORY

Were there any difficulties during the pregnancy? ☐ Yes ☐ No

If yes, please explain:

Length of pregnancy: _____ Length of labor: _____

Birth was: ☐ Vaginal ☐ Caesarian ☐ Breech ☐ Multiples Weight:

Did your child experience any of the following complications following delivery

Required breathing assistance ☐ Yes ☐ No

If yes, please explain:

Feeding difficulties ☐ Yes ☐ No

If yes, please explain:

Spot On Therapy Group

Has your child had any of the following?

- ☐ adenoidectomy
- ☐ tonsillitis
- ☐ chicken pox
- ☐ colds
- ☐ head injury
- ☐ sleeping difficulties
- ☐ high fevers
- ☐ respiratory/breathing difficulties
- ☐ allergies-please list:
- ☐ ear infections – how often?
- ☐ other hospitalizations/surgeries:
- ☐ encephalitis
- ☐ flu
- ☐ head injury
- ☐ thumb/finger sucking
- ☐ tonsillectomy
- ☐ meningitis
- ☐ cardiac problems
- ☐ mumps
- ☐ sinusitis
- ☐ seizures
- ☐ measles
- ☐ scarlet fever
- ☐ vision problems

Is your child currently on medication? ☐ Yes ☐ No
If yes, please specify below

Name of Medication	**Purpose**

Does your child have specialized equipment? ☐ Yes ☐ No
If yes, please specify below:

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Please check all of the following whom you have contacted and/or from whom you have received services concerning your child.

Area of Service	**Clinician/Practice**	**Dates Seen**	**Diagnosis/Recommendations**
Occupational Therapy			
Physical Therapy			
Speech Language Pathology			
Developmental Pediatrician			
Vision Specialist			
Hearing Specialist			
Behavior Specialist			
Neurologist			
Orthopedist			
Psychologist			
Counselor			
Other:			

Additional Provider Information to share:

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DEVELOPMENTAL HISTORY

Please check whether your child's skill achievement was "on time," delayed or is not yet mastered. Age ranges for typical development are in parentheses.

MOTOR:	**On time**	**Delayed**	**Not yet mastered**
Head control (3mos.)	☐	☐	☐
Reaching for objects (3 mos.)	☐	☐	☐
Roll over both ways (7-8 mos.)	☐	☐	☐
Finger feeding (7-8 mos.)	☐	☐	☐
Sitting alone (7-9 mos.)	☐	☐	☐
Creeping on all 4's (9 mos.)	☐	☐	☐
Pulling to stand (9 mos.)	☐	☐	☐
Eating with spoon (1-1.5 yrs.)	☐	☐	☐
Walking (1-1.5 yrs.)	☐	☐	☐
Jumping (2-3 yrs.)	☐	☐	☐
Hopping on one foot (3-4 yrs.)	☐	☐	☐
Drawing a circle (3-4 yrs.)	☐	☐	☐
Cutting with knife (5-6 yrs.)	☐	☐	☐
Cutting with scissors (5-6 yrs.)	☐	☐	☐
Riding a bike (5-6 yrs.)	☐	☐	☐

Does your child have difficulty learning new motor skills? ☐ Yes ☐ No

If yes, please explain:

Spot On Therapy Group

LANGUAGE:	**On time**	**Delayed**	**Not yet mastered**
Looks/responds when called (6-9 mos.)	☐	☐	☐
Looks in direction that others point (9-12 mos.)	☐	☐	☐
Said first word (1-1.5 yrs.)	☐	☐	☐
Pointing to simple pictures (1-1.5 yrs.)	☐	☐	☐
Following one step commands (1-1.5 yrs.)	☐	☐	☐
Combined words (1.5-2 yrs.)	☐	☐	☐
Following several step commands (1.5-2 yrs.)	☐	☐	☐
Spoke sentences (2-2.5 yrs.)	☐	☐	☐

SELF-HELP:	**On time**	**Delayed**	**Not yet mastered**
Bladder control (3 yrs.)	☐	☐	☐
Bowel control (3 yrs.)	☐	☐	☐
Toileting independently (3-4 yrs.)	☐	☐	☐
Snaps independently (4 yrs.)	☐	☐	☐
Buttons independently (4-5 yrs.)	☐	☐	☐
Zips independently (4-5 yrs.)	☐	☐	☐
Dressing independently (4-5 yrs.)	☐	☐	☐
Brushing teeth (4-5 yrs.)	☐	☐	☐
Tying shoes (5 yrs.)	☐	☐	☐
Brushing/combing hair (6-7 yrs.)	☐	☐	☐
Bathing independently (6-7 yrs.)	☐	☐	☐

Spot On Therapy Group

BEHAVIOR DURING INFANCY

Please select the characteristics that describe(d) your child as an infant:

	Yes	No	Sometimes		Yes	No	Sometimes
Cried a lot, fussy, irritable	☐	☐	☐	Liked being held	☐	☐	☐
Overly demanding	☐	☐	☐	Resisted being held	☐	☐	☐
Alert	☐	☐	☐	Floppy when held	☐	☐	☐
Quiet	☐	☐	☐	Tense when held	☐	☐	☐
Passive	☐	☐	☐	Good sleep pattern	☐	☐	☐
Active	☐	☐	☐	Irregular sleep pattern	☐	☐	☐

CURRENT BEHAVIOR

Please select the characteristics that describe your child at present:

	Yes	No	Sometimes		Yes	No	Sometimes
Mostly quiet	☐	☐	☐	Clumsy	☐	☐	☐
Overly active	☐	☐	☐	Struggles with separation	☐	☐	☐
Tires easily	☐	☐	☐	Nervous habits/tics	☐	☐	☐
Talks constantly	☐	☐	☐	Falls often	☐	☐	☐
Overly impulsive	☐	☐	☐	Wets bed	☐	☐	☐
Restless	☐	☐	☐	Wets/soils pants	☐	☐	☐
Stubborn	☐	☐	☐	Has poor attention span	☐	☐	☐
Resists change	☐	☐	☐	Frustrated easily	☐	☐	☐
Fights often	☐	☐	☐	Has unusual fears	☐	☐	☐
Usually unhappy	☐	☐	☐	Frequent temper tantrums	☐	☐	☐
Physically aggressive	☐	☐	☐	Seems anxious	☐	☐	☐

Toward whom? _____

Spot On Therapy Group

SCHOOL HISTORY

What is your child's hand preference? ☐ Right ☐ Left ☐ Mixed

Where does your child currently attend school? _____

What is your child's current grade level? _____

What are your child's strengths in school?

_____

_____

Is your child having any difficulties in school? ☐ Yes ☐ No

If yes, please explain:

_____

Is your child in a special class or receiving any support services? ☐ Yes ☐ No

If yes, please specify:

_____

Has your child repeated any grade levels? ☐ Yes ☐ No

If yes, please specify:

_____

What does the teacher say about your child?