INTAKE INFORMATION

Demographics

Child's Name: **Date of Birth:**

Address: **City:** **Zip:**

Phone(Cell): **Phone(H):**

Email Address:

Father's Name: **Address:**
(if different than above)

Father's Phone(Cell):

Mothers Name: **Address:**
(if different than above)

Mother's Phone(Cell):

Parents are (*Check One):* **____ Married ____ Single_____ Divorced _____ Deceased**

Referred Source: _____

Cultural/ Ethnicity: **__African American ___Chinese __Mixed __Hispanic**

___Latino ___American Indian/Alaska Native __Puerto Rican __White

__Asian or Pacific Islander _Asian Indian __Mexican __Middle Eastern

INSURANCE INFORMATION

Primary Insurance Name: _____
NOTE: Helping Hand is not in network with County Care or Humana.

Subscriber I.D. #:_____ **Group #:**_____

Subscriber Name:_____ **DOB:**_____

Secondary Insurance Name: _____

Subscriber I.D. #:_____ **Group #:**_____

Subscriber Name:_____ **DOB:**_____

Does you have prescription for therapy evaluation & treatment? _____

Referring Doctor

Physician's Name: _____

Address:_____

_____

Office Phone: _____Fax #:_____

Recommended Services: __OT ___ST __Counseling

PRESENTING PROBLEM:

_____

_____

_____

_____

Appointment Details

Virtual, in person, or first available appointment preference?_____

Desired days of the week and time of day available for therapy appointment:

_____

_____