O Therapy Services, LLC

Karen Oberg, OTR/L, RYT

800 Kensington, Suite 100
Missoula, MT 59801

Client Intake

Name: _____Date:_____ Act. #_____

Date of Birth: _____ Sex: _____ Male _____ Female

Parents/Caregiver: _____

Address: _____

City: _____ State_____ Zip: _____

Daytime Phone: _____ Cell Phone: _____

E-mail:_____

Emergency Contact Name/Number: _____

Name of Insured: _____DOB:_____

Address if different from Client: _____

Insurance Carrier: _____

Policy ID#: _____Group #: _____

Address: _____

Telephone: _____Time/Date Insurance Verification: _____

Primary Healthcare Provider: _____Provider NPI:_____

Practice Name_____

Provider's Address: _____

City: _____ State_____ Zip: _____

Telephone #: _____ Fax #: _____

Prescription for services (Yes or No):_____ Date Received: _____

Diagnosis/code or description of problem_____

Please list any other services and providers (speech, physical therapy, CDC, Full Circle, Aware, counseling, etc.) your child is currently receiving and other extra-curricular activities that he/she is participating in:

_____

_____

_____

If applicable, what is/are your child's diagnosis(es)?

_____

_____

Who diagnosed your child? _____

Does your child have any siblings? If so, how many and what age?_____

_____

Does your child take any medications?_____

_____

What do you hope to get from this type of therapy approach?_____

_____

What would you most hope to have addressed?_____

_____

_____

What else would you like me to know (use the back of page if you need more space)?

Notice of Privacy Practice:

I verify that I understand the HIPAA Privacy Practices and that it has been presented to me in written form and was offered for my personal records.

Signature: _____ Date: _____