Aspire Therapies, LLC

2851 Stage Village Cove, Suite 2, Bartlett, TN 38134
Phone (901) 949-9488 · Fax (800) 420-3359

Form 1: New Patient Intake & Child History

Please complete one form per child. If a question doesn't apply, leave it blank. Your therapist will go over anything you're unsure about at the evaluation.

Child information

Field	Answer
Child's legal first name	
Middle name	
Last name	
Suffix (Jr., Sr., II, III, other)	
Preferred name / nickname	
Date of birth (MM/DD/YYYY)	
Sex assigned at birth	Select
Primary language spoken at home	
Other languages spoken at home	
Street address	
Apt / suite	
City	
State	
ZIP code	
Daycare or school name	
Grade / classroom	

Parent or legal guardian

Field	Guardian 1	Guardian 2
First name		
Middle name		
Last name		
Relationship to child		
Mobile phone		
Email		

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Field	Guardian 1	Guardian 2
Address: street, apt, city, state, ZIP (if different from child)		
Has legal custody? (Yes / No / Shared)		

If there is a custody or court order that affects who may consent to care or receive information, please provide a copy.

Emergency contact (other than guardians)

Name	Relationship	Phone

Insurance

Field	Primary	Secondary (if any)
Insurance company		
Plan type (Commercial / TennCare / TEIS)		
Member ID		
Group number		
Policyholder name		
Policyholder date of birth (MM/DD/YYYY)		
Policyholder relationship to child		

Please upload a photo of the front and back of each insurance card.

Referring and primary care provider

Field	Answer
Pediatrician / primary care provider	
Practice name	
Practice phone	
Referring provider (if different)	
Services requested	☐ OT ☐ Speech ☐ Both ☐ Not sure
How did you hear about Aspire?	

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Your concerns

1. What are your main concerns about your child's development right now?
2. When did you first notice these concerns?
3. What would you most like your child to be able to do after therapy?
4. Has anyone else (teacher, doctor, daycare) shared concerns? What did they say?

Pregnancy, birth and early development

1. Was your child born full-term? If not, at how many weeks?
2. Any complications during pregnancy, delivery, or a NICU stay?
3. At about what age did your child: sit alone, crawl, walk, say first words, put two words together, become toilet trained?

Medical history

Question	Answer
Diagnoses (e.g. autism, ADHD, Down syndrome, cerebral palsy)	
What have you noticed that led to this OT and/or speech evaluation? (e.g. trouble with handwriting, feeding, sensory needs, coordination, talking or being understood)	

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Question	Answer
Who else has noticed these concerns? (check all that apply: parent/guardian, primary care provider, teacher, daycare staff, other) What did they share, and when were the concerns first noticed?	
Current medications	
Allergies (food, medication, latex, other)	
Hearing tested? Date and result	
Vision tested? Date and result	
Seizures, heart, or breathing conditions	
Surgeries or hospital stays	
Ear infections or ear tubes	
Any dietary restrictions	

Past and current services

1. Has your child had OT, speech, PT, ABA, or developmental therapy before? Where, and when?

2. Does your child have an IFSP (TEIS), IEP, or 504 plan? Please upload a copy if you have one.

3. Any past evaluations? Please upload copies.

Daily life (check any that are a concern)

- ☐ Feeding or picky eating
- ☐ Sleep
- ☐ Dressing, bathing, or toileting
- ☐ Handwriting or using utensils, crayons, scissors
- ☐ Balance, coordination, or clumsiness

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- ☐ Reacting strongly to noise, touch, textures, or movement
- ☐ Following directions
- ☐ Being understood by others
- ☐ Understanding what others say
- ☐ Stuttering
- ☐ Playing with other children
- ☐ Behavior, meltdowns, or transitions

Your child, in your words

1. What does your child love? Favorite toys, activities, characters, or rewards?

2. What helps your child feel calm when upset?

3. Anything else you'd like your therapist to know?

Completed by (name) **Relationship**

Date