Alyssa Frey, M.S., OTR/L, LLC
509 Valley St. Maplewood, NJ 07040
info@alyssafreycst.com

INFANT INTAKE FORM (ages 0 - 24 months)

1. General Information

Child's name ____

Parent's name ____

Phone ____

Address ____

Email ____

Pediatrician ____

Referred by ____

Medical issues/procedures ____

Current medications ____

2. Prenatal Health of Mother

Medical issues ____

____

Genetic testing ____

Medications ____

Stress ____

Exercise ____

Difficulty conceiving ____

Family history of allergies ____

3. Birth

Type of delivery ____

Interventions (forceps, vacuum, epidural, caesarean) ____________________________________

Duration of delivery ____

Location of delivery (hospital, home, birthing center)____________________________________

Support staff (midwife, doula) ____

Other ____

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4. Feeding

Breastfeeding/bottle ____

Quality of latch and suck ____

Is feeding easier one side than the other? ______________________________________

Birth weight ___________________________________

Current weight _________________________________

Other (feeding pattern) ____

5. Digestive

Colic (Yes/No): _____________

Reflux (Yes/No): _____________

Arching pattern (Yes/No): _____________

Flatulence (Yes/No): _____________

Bowel habits: ____

6. **Sleep patterns**

Family bed, crib and patterns ____

____

7. Current therapies child is receiving:

____

____

____

8. Main goals of therapy

____

____

____

____

Parent/Guardian signature *(sign by entering first and last name)*

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DISCLOSURES TO INDIVIDUALS AND HIPAA PRIVACY AUTHORIZATION FORM

There may be times when it is necessary for an individual involved in your care to call me to inquire about your personal health information or billing information. Please take a few moments to complete this section.

I authorize Alyssa Frey, M.S., OTR/L, LLC to use and disclose health information related to my current treatment to: *Please indicate name, relationship, and other relevant information.*

1.____

2. ____

3. ____

4. ____

5. ____

This authorization for release of information covers all past, present, and future periods.

☐ **I authorize the release of my complete health record.**

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature: _________________________________

Indicate relationship to client (e.g., parent, guardian) __________________________________

Date: __________________

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CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE

I voluntarily consent to have Alyssa Frey, M.S., OTR/L, LLC, provide evaluation and/or treatment. I understand the practice of Occupational therapy and Craniosacral therapy is not an exact science, and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand that the treatment I receive is limited to Occupational therapy services and/or Craniosacral therapy and that I shall seek treatment from other medical professionals for all other issues I may experience. I understand that I have the right to ask questions at any time during the course of my care.

I further authorize Alyssa Frey, M.S., OTR/L, LLC to release to appropriate agencies, any information acquired during my, or the above-named, examination and treatment necessary to secure payment for services provided.

Signature: ________________________________

Relationship to client (e.g., parent, guardian) ____________________________________

Date: ___________________