Springboard Pediatric Therapy Initial Intake Form

Today's Date: _____

Child's Name: _____

Parents' Names:_____

Date of Birth: _____

Diagnoses:_____
Diagnoses Code (required if you expect to use your out of network benefits and provided by a physician):_____

Address: _____

Phone: (cell)_____ (home or other)_____

Email:_____

How did you hear about us/referred by?_____
_____

List Pediatricians, Doctors, Therapists, Specialists and/or School Teachers:
1.
2.
3.
4.

Please provide us with permission to contact/speak your Pediatrician/Doctor
_____

Please list your top three concerns for today's evaluation/consultation:
1.

2.

3.

***** Please note- if you choose to use your out of network benefits- you must contact your insurance company prior to initiating therapy*****