Serenity Pediatric Therapies
SPEECH, LANGUAGE, FEEDING, & SWALLOWING

2026 Child **Intake** Packet/History

Today's Date: _____

Patient/Caregiver Information:

Client Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ Male Female

Diagnoses (if known):

_____

_____

Parent(s) / Guardians: _____

Street Address: _____

City, State, Zip: _____

Phone #1: _____ Cell Home Work Other

Phone #2: _____ Cell Home Work Other

Email #1: _____ Email #2: _____

How did you hear about us: _____

Emergency Contact Name: _____

Emergency Contact Relationship to Child: _____

Emergency Contact (Information): _____

Client's Primary Physician: _____

Physician Phone Number: _____

Physician Address: _____

Other Physicians / Specialists Involved in Care:

Referring Physician (if different than Primary): _____

Phone Number: _____

Physician Address: _____

Other Physicians and Specialists:

_____

_____

Name of Insurance Company: (If Medicaid, you only need to add the Member ID and Branch of Medicaid)

_____

Insurance Phone # _____

Member ID # including alpha prefix if applicable: _____

Group #: _____

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Primary Insured Name (if applicable): _____
Primary Insured Date of Birth (if applicable): _____
Primary Insured Address (if different than the patient)
_____
Relationship to patient (Check one): Self_____ Spouse_____ Child____ Other_____

Family Background:

Parent 1 Name: _____ Parent 2 Name: _____
Age: _____ Age: _____
Occupation: _____ Occupation: _____
Marital Status: Single Married Separated Divorced

What adults does the child live with? Circle all that apply:
Birth Parent(s) Adoptive Parent(s) Foster Parent(s) Grandparent(s) Both Parents Parent 1 Only Parent 2 Only
Other:

Does the child have siblings or are there other siblings in the home?
Child 1 Name: _____ Age: _____ M F Health: _____
Child 2 Name: _____ Age: _____ M F Health: _____
Child 3 Name: _____ Age: _____ M F Health: _____
Child 4 Name: _____ Age: _____ M F Health: _____

Is there anything additional you would like to share about the family / home environment?
_____

Medical History:

Describe any pertinent information about your child's medical history (surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom:
_____
_____

Mother's Health During Pregnancy:

Were there any infections or illnesses prenatally or during labor? Yes No If yes, please describe:
_____
What was the mother's age at the time of delivery? _____ years
Were there any complications for mom during labor or delivery? Yes No
If yes, describe:
_____

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Child's Health:

How many weeks gestation was the child when born? _____ weeks (40 weeks is typical)

The child was _____ lbs ____oz

How was the child delivered? Vaginally Cesarean Section

Were there any complications for your child during labor or delivery? Yes No If yes, describe:

_____

Indicate and describe all that apply:

Tonsillectomy	Yes	No
Adenoidectomy	Yes	No
Asthma or other breathing problems	Yes	No
Behavior Issues	Yes	No
Cardiac Issues	Yes	No
Ear Infections	Yes	No
Tubes in ears	Yes	No
Hearing loss	Yes	No
Encephalitis	Yes	No
Meningitis	Yes	No
Mumps	Yes	No
Seizures	Yes	No
Sensory Issues	Yes	No
Sleep Issues	Yes	No
Tongue Tie	Yes	No
Traumatic Brain Injury	Yes	No
Vision Issues	Yes	No

If yes to any of the above, please describe in further detail:

_____

_____

_____

Has your child had any surgeries or ever been hospitalized? Yes No

If yes, please list when and why:

_____

_____

Is your child currently on any medications? Yes No

If yes, please list the medications, the dosage, and what the medicine is for:

_____

_____

_____

Does your child have any known allergies? Yes No
If yes, please list allergens:
_____

Does your child use any equipment such as a communication device, walker, wheelchair, etc.? Yes No
If yes, please list and/or describe:
_____

Have you had your child's hearing checked? Yes No
If yes, when and the result:
_____

Have you had your child's vision checked? Yes No
If yes, when and the result:
_____

Feeding History

Does your child do any of the following:

Choke on liquids Choke on foods
Avoid foods Maintain a special diet whether it be food or liquid
Use a pacifier Suck thumb

Please describe any of the above that was indicated:
_____
_____
_____

Serenity Pediatric Therapies/ Michelle Layman
Location Address: 325 E 2nd Street, Marion, IN 46952
Mailing Address: Same
michelle.layman@serenitypediatric.com
765-661-7373

Consent for Services

☐ I authorize Serenity Pediatric Therapies to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time with Serenity Pediatric Therapies in writing. In addition, Serenity Pediatric Therapies may terminate services by notifying me in writing.

☐ I do not give my consent or am withdrawing my consent regarding Serenity Pediatric Therapies rendering evaluation and/or therapy services to the client named below.

_____ _____
Print Name of Client Date

_____
Client Date of Birth

_____ _____
Signature of Client or Legal Representative Relationship to Client

Communication Preference Form

Client Name: _____ Date of Birth: _____
In effort to ensure your privacy, it is important for us to understand your preferred method of receiving and communicating medical and administrative information pertaining to your child's therapy. As such, please indicate your communication preferences below.

For medical and administrative information pertaining to my child, such as clinical documentation, appointment reminders, therapy updates, etc., I hereby grant permission to Serenity Pediatric Therapies to do the following:

Written Documentation and Verbal Information:

Yes	No	
		I grant permission to provide me with written communication via HIPAA compliant encrypted email service via my email provided.
		I grant permission to provide me with written communication via unencrypted email service. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.
		I grant permission to provide me with written communication (such as appointment reminders or cancellations) via text message. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.
		I grant permission to provide me with written communication via USPS in an unmarked envelope.
		I elect to receive clinical information in person or via telephone through the number(s) provided.
		I grant permission to leave relevant medical information on my answering machine or voicemail. I also give permission to release medical information pertaining to the client to the individuals listed below.

Sharing of Information (Please include parent(s) and caregiver(s) along with anyone else you'd like to include.)

Individual's Name	Relationship to Client	Email Address and/or Phone Number
1.		
2.		
3.		
4.		

We offer appointment reminders!

Please check which option you would prefer:
_____ Reminder sent via email. The email I would like you to use is: _____
_____ Reminder sent via text message (SMS). The cell number to use is: _____
_____ I do not want to receive appointment reminders.

I understand that it is my responsibility to inform the practice of changes to my preferred contact information or my communication preferences, as well as, to revoke this authorization at any time.

Print Name of Client: _____
Print Name of Legal Representative: _____ Relationship to Client: _____
Signature of Client's Legal Representative: _____ Date: _____

Serenity Pediatric Therapies/ Michelle Layman
Location Address: 325 E 2nd Street, Marion, IN 46952
Mailing Address: Same
michelle.layman@serenitypediatric.com
765-661-7373

Cancellation/No Show Policy

Thank you for choosing Serenity Pediatric Therapies to serve you and your child. We are committed to providing you with the highest quality care. Please know that regular attendance is an important part of your child's success and as such, this policy is an agreement between you and Serenity Pediatric Therapies for good attendance. As a client of Serenity Pediatric Therapies, you are required to carefully review and sign our cancellation/no show policy. Thank you for working alongside Serenity Pediatric Therapies.

Please read the following information carefully and initial the box to indicate that you read and understand each statement:

____ Regular, punctual attendance is expected. If you cannot attend a scheduled session, please call as soon as you know. 24-48 hour notice should be given whenever possible for vacations, Dr. appointments, and other situations that are not due to emergency or illness.

____ Please keep your child home if they are sick and contagious. Serenity Pediatric Therapies reserves the right to send a child home if there is a fever or if the child appears to be contagious. This is in the best interest of all families and employees.

____ If at all possible, canceled sessions will be rescheduled for later in the week. This is for cancellations made by the family as well as cancellations by staff.

____ Excessive cancellations on the part of the family may end in discharge of the child from services. If you reschedule a cancellation within the same week, the initial cancellation will not count against the child's attendance.

____ No call, no show appointments are not acceptable. If there are 3 no call, no show appointments within any given 6 month period, the child will be discharged from services.

_____ _____
Print Name of Child Date

_____ _____
Signature Guardian or Responsible Party Relationship to Child

_____ _____
Private Practitioner / Witness Date

Serenity Pediatric Therapies/ Michelle Layman
Location Address: 325 E 2nd Street, Marion, IN 46952
Mailing Address: Same
michelle.layman@serenitypediatric.com
765-661-7373

Authorization to Exchange, Obtain or Release Information

Client Name: _____ Date of Birth: _____
Home Address: _____
_____
Parent/Guardian(s): _____
Phone Number: _____

For the purpose of providing the best care, I do hereby give permission for a mutual exchange of the below indicated documents/information concerning the above client. Please list only one location per Authorization Release Form.

Between Serenity Pediatric Therapies and the following: (Hospital, Clinic, Physician, Institution, Association, or School)	
Mailing Address:	
Contact Person(s):	
Contact Phone:	
Contact Fax:	

(Please check all that apply.)

	Release all information
	Identifying Data (Name, Address, DOB, Grade Level, Attendance
	Medical Reports
	Psychological Reports
	Psychiatric Reports
	Other: (Please Specify)

☐ I grant permission for the mutual exchange of information (as described above) via written and mailed report, phone call, meeting, email, or fax. I understand that I may revoke this in writing at any time.

_____ _____
Print Name of Client Date

_____ _____
Signature of Legal Representative Relationship to Client