158 Newark Ave.
Jersey City, NJ 07302
T: (201) 324-1700 / F: (201) 324-1788
info@sensorykidsandsocialminds.com
www.sensorykidsandsocialminds.com

CLIENT INFORMATION & PARENT QUESTIONNAIRE

Please provide us with the following information so we can best serve your child.

Child's Full Name (Last, First): _____

Date of Birth:___/___/___ Age: _____ Sex: F ☐ M ☐

Parent/Guardian Name: (Mr./Ms./Miss) _____
(Mr./Ms./Miss) _____

Marital Status: _____ Language(s) Spoken: _____

Siblings Names: _____
_____

Home Address: _____
_____

Primary Contact #: (____) _____- _____
Please Circle: (Home/Work/Cell)

Secondary Contact #: (____) _____- _____
Please Circle: (Home/Work/Cell)

Email: _____
Would you like to receive emails regarding upcoming workshops/programs? Yes ☐ No ☐

****

Person responsible for bill: _____

Date of Birth: _____ Address (if different): _____

Phone # (if different): (_____) _____- _____ Work #: (_____) _____- _____

Employer Name: _____ Occupation: _____

Employer's Address: _____

****

How did you learn about Sensory Kids & Social Minds?

_____

Reference's Name, if any:

_____

Why are you seeking our services?

_____

Thank you for your cooperation in filling out this form.

158 Newark Ave.
Jersey City, NJ 07302
T: (201) 324-1700 / F: (201) 324-1788
info@sensorykidsandsocialminds.com
www.sensorykidsandsocialminds.com

Child's Physician(s)

_____

Other Health Professionals, Agencies, or Medical Professionals working with your child?

_____
_____
_____

List current school or childcare provider:

_____
_____

List previous school/daycare experiences:

_____
_____

List services your child receives in school: (i.e. OT, PT, S/L, EH, TMH, etc.)

_____
_____

TELL US MORE ABOUT YOUR CHILD

Please answer the following to the best of your knowledge:

Describe your child's development as compared to other children of the same age:

_____
_____
_____

What are child's strengths?

_____
_____
_____

What do you find difficult for your child to accomplish?

_____
_____
_____

Does your child have difficulty understanding or following directions?

_____
_____
_____

158 Newark Ave.
Jersey City, NJ 07302
T: (201) 324-1700 / F: (201) 324-1788
info@sensorykidsandsocialminds.com
www.sensorykidsandsocialminds.com

Describe how your child gets along with other children:

_____
_____
_____

YOUR CHILD'S LIKES/DISLIKES

Please answer the following to the best of your knowledge:

What does your child's dislike?

_____
_____

Please list your child's favorite play activities/toys?

_____
_____

What are your child's favorite foods?

_____
_____

Is your child a picky eater? Yes ☐ No ☐ If so, please explain below:

_____
_____

YOUR CHILD'S PAST MEDICAL HISTORY

Please answer the following to the best of your knowledge:

Has your child had any ear infections? Yes ☐ No ☐
If so, please indicate how often and how they were treated for it below:

_____
_____

Does your child seem overly sensitive to noises, light, crowds, texture/touch, clothing, (etc.)
Yes ☐ No ☐ If so, please describe below:

_____
_____
_____

Does your child grind their teeth during the day/or night? Yes ☐ No ☐
If so, do they clench their jaw? Yes ☐ No ☐ If so, please describe below:

_____
_____

158 Newark Ave.
Jersey City, NJ 07302
T: (201) 324-1700 / F: (201) 324-1788
info@sensorykidsandsocialminds.com
www.sensorykidsandsocialminds.com

Please describe any family history of health, mental, emotional, or learning difficulties:

_____
_____
_____

YOUR COMMENTS/CONCERNS

Please answer the following to the best of your knowledge:

Please describe mealtime routines or concerns:

_____
_____
_____
_____

Please describe bedtime routines or concerns:

_____
_____
_____
_____

Please describe any toileting concerns:

_____
_____
_____

Please share any other information that you feel will be helpful to us in working with your child/family:

_____
_____
_____
_____
_____
_____

INSURANCE INFORMATION:

Sensory Kids & Social Minds, LLC, is an out of network provider. Insurance reimbursement is dependent on your insurance plan and policies. Please be advised that a diagnosis is needed for insurance consideration.

Has your child had any clinical evaluations (e.g. Pediatrician, Neurologist, Psychiatrist)?
Yes ☐ No ☐ If so, when and where was it conducted?

_____

158 Newark Ave.
Jersey City, NJ 07302
T: (201) 324-1700 / F: (201) 324-1788
info@sensorykidsandsocialminds.com
www.sensorykidsandsocialminds.com

Please indicate whether your child received a clinical diagnosis? Yes ☐ No ☐
Diagnosis, if any: _____

Primary Insurance Name: _____

Member ID#: _____ Group #: _____

Policy Holder's Full Name: _____

Policy Holder's Date of Birth:___/___/___ S.S. #: _____-_____-_____

Please indicate whether you have a Secondary Insurance: Yes ☐ No ☐
Secondary Insurance Name: _____

Policy Holder's Full Name: _____

Member ID#: _____ Group #: _____
Other _____

****

Financial Agreement:

Our practice is committed to providing the best treatment for our patients. Patients are responsible for all charges from treatments provided by Sensory Kids & Social Minds, LLC. As a service to you, we will bill most insurance carriers directly. However, primary responsibility for the account is yours. Providing correct insurance billing information is the responsibility of the patient. If your insurance changes, please present your insurance card at your next visit.

Minors:

The undersigned will agree to be responsible for payment of balance for services rendered to minors.

Insurance Billing:

Please be aware that some or perhaps all of the services you receive may be non-covered services and are not considered reasonable and/or necessary under your insurance plan. In this instance, you will be responsible for payment.

No Insurance:

Payment for services is due at the time services are rendered.

158 Newark Ave.
Jersey City, NJ 07302
T: (201) 324-1700 / F: (201) 324-1788
info@sensorykidsandsocialminds.com
www.sensorykidsandsocialminds.com

Cancellation Policy:

Your appointment time is especially reserved for you. If you need to cancel for any reason, you must allow us at least 24 hours advance notice. Failure to do so will result in a 50% service charge to your appointment. In trying to do our best to serve you we recommend that you always reschedule and confirm your appointments before leaving the office.

Payment Agreement and Consent for Evaluation, Treatment, and/or Program:

We will gladly discuss your proposed treatment and answer any questions relating to your insurance and/or payment arrangements.

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services rendered.

I am also providing my consent for evaluation/treatment and/or participation in Sensory Kids & Social Minds' Program for _____.
(Print Name of Child)

I have read all the information on this sheet and I will notify you of any changes that might interfere with this financial agreement.

_____ _____

Signature (Parent or Guardian): Today's Date:

_____ _____

Parent/Guardian's Full Name (Print Name): Today's Date: