



Welcome to Jabbergym! We are thrilled to join you in the wonderful journey of your child's development.

Jabbergym is a private practice providing speech language and communication therapy, physical therapy, occupational therapy, in-home early infant education, developmental playgroups, handwriting and social skills groups.

We serve children having speech and language disorders and delays, fine and gross motor challenges and other developmental needs. Our professionals specialize in childhood apraxia of speech, sensory integration, autism services and handwriting.

We serve children birth to 22 years of age and are funded by Alta California Regional center, local school districts and families who choose to pay us directly.

Our philosophy at Jabbergym is to successfully promote growth and development by addressing the needs of the whole-child. By evaluating specific areas of strengths and challenges, our multidisciplinary team, including speech language pathologists, physical therapists, occupational therapists and early infant educators partner with the family to create an individualized intervention plan for development.

Included in this introductory packet you will find information and helpful tips to ensure a successful therapy experience at Jabbergym

## **THERAPY SESSIONS**

**Check-In:** Upon arrival at Jabbergym, you will be greeted by our office managers. Please check-in at the front desk by signing in on our clipboard. Feel free to use the toys and books in the waiting room while you wait for your child's clinician. Our bulletin boards and information binders are a great way to gain access to developmental articles and learn about community events and upcoming trainings.

**Cleanliness and Safety:** We ask that both the adults and children entering our facilities remove their shoes to maintain a clean and sanitary environment. Please wear socks. We respectfully request that children wash their hands prior to therapy and upon leaving to assist us in our philosophy that a clean and safe environment is a happy environment.

**Parent/Caregiver Participation:** Your child's therapist will meet you in the waiting room and escort both of you to the therapy room. It is requested that parents/caregivers participate in sessions. We believe that a parent knows their child best and are a child's best teacher. We encourage open communication in every session and welcome interaction and feedback.



**Tips for a Successful Therapy Session:** Jabbergym therapists achieve your child's successful participation in therapy via strategies such as use of instructional control via positive reinforcement. This means that we help your child follow directions and participate in therapy activities by allowing them to work for a favorite toy or activity. Our sessions are always fun and interactive to support our philosophy that a child learns best during play.

Although it may be difficult, we ask that you leave your child's blankets, snacks, bottles and pacifiers in the car as these items frequently interfere with participation. For our older children, please leave gum, cell phones and ipods at home.

Please note that therapists will provide a written note and homework at the conclusion of every session. A child will make the most progress if skills are worked on in the home setting on a daily basis.

**Thematic Units:** Jabbergym organizes our therapy sessions around thematic units. Organized themes facilitate skill development and provide children with an exciting, dynamic environment in which to learn. From the moment you enter our facilities, be prepared to enjoy our Winter Wonderland, Jungle Safari, Transportation Fun, Under the Sea, or Down on the Farm.

## **POLICIES**

**Assistant Disclosure:** Jabbergym employs California Licensed Speech Therapy and Certified Occupational Therapy Assistants in our clinics. Our assistants are highly qualified and supervised under State criteria and follow guidelines developed to ensure that services provided are of the highest quality. Please note that your child may be scheduled with a licensed assistant for therapy at Jabbergym.

**Cancellation Policy:** It is in the best interest of clients and their families to attend therapy sessions consistently to provide the greatest opportunity for skill improvement. As a result, Jabbergym enforces a strict cancellation/no-show policy. Please note that a CANCELLATION is defined as a phone call before 8am on the day of the appointment. A NO-SHOW is a cancellation after 8am on the day of the appointment and/or not showing up for the appointment. Please note that clients may be terminated from therapy with Jabbergym in the case of three no-shows or frequent cancellations in a three month period.

Because Jabbergym is a dynamic organization, it reserves full discretion to add to, modify, or delete provisions of this notice at any time. When such changes are made, caregivers shall be notified of the changed policy or procedure.



JABBERGYM INITIAL CLIENT INTERVIEW

Child's Name: \_\_\_\_\_
Birth date: \_\_\_\_\_
Chronological Age: \_\_\_\_\_
Adjusted Age: \_\_\_\_\_
Gender: \_\_\_\_\_

Parent(s): \_\_\_\_\_
Address: \_\_\_\_\_
Home Phone: \_\_\_\_\_
Cell Phone: \_\_\_\_\_
Email: \_\_\_\_\_

Referral Information:

School District: \_\_\_\_\_
School of Attendance: \_\_\_\_\_
Name/Number of Program Specialist: \_\_\_\_\_

Birth History:

Please describe prenatal care: \_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Please describe/explain labor and delivery: (NICU, natural or C-section, immediate medical attention)

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Delivered at \_\_\_\_\_ weeks gestation Child's birth weight: \_\_\_\_\_

Please describe any complications after birth: \_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Does your child have a Diagnosis? \_\_\_\_\_
\_\_\_\_\_

Please describe your child's delay: \_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

**Medical History:**

Pediatrician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Other Medical Specialists: \_\_\_\_\_

Current Health Concerns/Medications:

\_\_\_\_\_  
\_\_\_\_\_

Has your child had any previous therapy? If yes, what type, when, and where?

\_\_\_\_\_  
\_\_\_\_\_

Any surgeries/ hospitalizations (past or future):

\_\_\_\_\_  
\_\_\_\_\_

Allergies/Asthma/Respiratory Problems:

\_\_\_\_\_  
\_\_\_\_\_

Vision Screening (date and results):

\_\_\_\_\_  
\_\_\_\_\_

Audiological Screening (date and results)

\_\_\_\_\_  
\_\_\_\_\_

Ear infections (how many since birth?):

\_\_\_\_\_  
\_\_\_\_\_

Overall Health is described as:    \_\_\_Excellent \_\_\_ Good \_\_\_Fair \_\_\_Poor

**Motor Development:**

At what age did your child...

Roll: \_\_\_\_\_ Sit: \_\_\_\_\_ Crawl: \_\_\_\_\_ Walk: \_\_\_\_\_

Does your child use any adaptive equipment/Orthotics? \_\_\_\_\_

What are your concerns or questions with respect to your child's mobility:

\_\_\_\_\_  
\_\_\_\_\_

**Feeding:**

Describe difficulties with solids or liquids? \_\_\_\_\_

\_\_\_\_\_

Is your child's diet restricted? In what way? \_\_\_\_\_

\_\_\_\_\_

**Speech and Language History:**

Describe any known Family History of Speech and Language Challenges:

\_\_\_\_\_

\_\_\_\_\_

How does your child get his/her needs met or currently communicate (pointing, words, vocalizing)?

\_\_\_\_\_

\_\_\_\_\_

Did or does your child use a pacifier, suck his/her thumb, use a "sippy" cup, or drink from a bottle?

If so, for how long and how often? \_\_\_\_\_

\_\_\_\_\_

**Behavior and Play:**

Please list your child's siblings and ages? \_\_\_\_\_

Describe your child's interactions with family members and siblings: \_\_\_\_\_

\_\_\_\_\_

Does your child participate in child playgroups or attend daycare? \_\_\_\_\_

**Daily Routines:**

What are your child's favorite activities? \_\_\_\_\_

What are your child's least favorite activities? \_\_\_\_\_

When left alone how does your child like to spend time? \_\_\_\_\_

What things does your child tend to fear/avoid? \_\_\_\_\_

Does your child have difficulty transitioning between tasks? \_\_\_\_\_

Does your child have difficulty transitioning between environments? \_\_\_\_\_

**Self Care Skills:**

Does your child dress and undress independently? Explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child remove/put on shoes and socks independently? Explain.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child eating with a spoon and/or fork? Explain.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child drink out of an open mouth cup? \_\_\_\_\_

Does your child brush their teeth independently? \_\_\_\_\_

Is your child toileting independently? \_\_\_\_\_

**Sensorimotor History** *(Please check all that apply and leave those that are not applicable blank)*

**VISUAL/AUDITORY**

- Tends to draw some letters/numbers backward? YES\_\_\_ NO\_\_\_
- Seems irritated by bright lights? YES\_\_\_ NO\_\_\_
- Has difficulty with hand-eye coordination? YES\_\_\_ NO\_\_\_
- Becomes overly active when surrounded by too many stimuli? YES\_\_\_ NO\_\_\_
- Covers eyes or ears? YES\_\_\_ NO\_\_\_
- Avoids certain noises or noisy environments? YES\_\_\_ NO\_\_\_

**VESTIBULAR**

- Enjoys swings, slides, jumping on the bed? YES\_\_\_ NO\_\_\_
- Have good balance? YES\_\_\_ NO\_\_\_
- Enjoys merry-go-rounds or fast carnival rides? YES\_\_\_ NO\_\_\_
- Ever becomes carsick? YES\_\_\_ NO\_\_\_
- Jumps a lot? YES\_\_\_ NO\_\_\_
- Dislikes being tossed or whirled about by an adult? YES\_\_\_ NO\_\_\_
- Ever hesitate, or have difficulty going down stairs? YES\_\_\_ NO\_\_\_
- Ever hesitate, or avoid climbing or playing on equipment That is off the ground (i.e. playground ladder, tire swing etc.) YES\_\_\_ NO\_\_\_
- Likes to spin or whirl more than most children? YES\_\_\_ NO\_\_\_

**SMELL/TASTE**

- Tends to explore with smell, deliberately smells objects? YES\_\_\_ NO\_\_\_
- Seems overly sensitive to odors? YES\_\_\_ NO\_\_\_
- Seems to taste flavors as well as most people? YES\_\_\_ NO\_\_\_

**TACTILE**

- Tends to examine objects thoroughly with hands? YES\_\_\_ NO\_\_\_
- Seems to crave being held, cuddled or touched? YES\_\_\_ NO\_\_\_
- Dislikes being touched unexpectedly? YES\_\_\_ NO\_\_\_
- Tends to wear coat when not needed? YES\_\_\_ NO\_\_\_
- Dislikes the texture of certain clothing? YES\_\_\_ NO\_\_\_
- Avoids getting hands into paste, finger paint or messy things? YES\_\_\_ NO\_\_\_
- Seems overactive or wiggly? YES\_\_\_ NO\_\_\_
- Tends to bump, hit or push others? YES\_\_\_ NO\_\_\_
- Will only eat foods with certain textures? YES\_\_\_ NO\_\_\_
- Tends not to feel pain as much as other children? YES\_\_\_ NO\_\_\_
- Tends to be more sensitive to pain than other children? YES\_\_\_ NO\_\_\_
- Difficulty tolerating teeth brushing or hair washing? YES\_\_\_ NO\_\_\_

**PROPRIOCEPTION AND MOTOR SKILLS**

- Seems weaker or stronger than others his/her age? YES\_\_\_ NO\_\_\_
- Frequently grasps objects too tightly? YES\_\_\_ NO\_\_\_
- Seems to drop things easily? YES\_\_\_ NO\_\_\_
- Uses both hands equally? YES\_\_\_ NO\_\_\_
- Prefers playground activities to table activities and crafts? YES\_\_\_ NO\_\_\_
- Tends to prefer table activities to more active play? YES\_\_\_ NO\_\_\_
- Tends to deliberately fall, tumble, or bump head? YES\_\_\_ NO\_\_\_
- Has difficulty trying to jump, hop or skip? YES\_\_\_ NO\_\_\_
- Has difficulty throwing or catching a ball? YES\_\_\_ NO\_\_\_
- Walks on toes, or did so when younger? YES\_\_\_ NO\_\_\_
- Tires easily with physical activity? YES\_\_\_ NO\_\_\_
- Does your child fall out of their chair often for no apparent reason? YES\_\_\_ NO\_\_\_

**SOCIAL**

- Enjoy being with other children, makes friends easily? YES\_\_\_ NO\_\_\_
- Tend to have trouble getting along with other children? YES\_\_\_ NO\_\_\_
- Tend to prefer to play alone? YES\_\_\_ NO\_\_\_
- Have a strong desire for routine? YES\_\_\_ NO\_\_\_
- Tend to crave attention? YES\_\_\_ NO\_\_\_
- Lacking confidence/self-esteem? YES\_\_\_ NO\_\_\_
- Have strong outbursts or anger rages? YES\_\_\_ NO\_\_\_
- Tend to be active and aggressive? YES\_\_\_ NO\_\_\_
- Tend to be heedless, impulsive? YES\_\_\_ NO\_\_\_

**Fine Motor History:**

How does your child pick up small objects? Explain (whole hand, pinch, thumb side of hand etc.)

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How does your child hold crayon/pencil while writing/coloring? Explain (fisted-thumb down, fisted-thumb up, three-finger etc.)

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- Small manipulative activities tend to be difficult? YES\_\_\_ NO\_\_\_





**Other Information:**

Please share other information that you feel is important for Jabbergym to know about your child.

Strengths: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Weaknesses: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What goals would you like to see your child accomplish through therapy?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any other information you would like us to know about your child?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**PATIENT INFORMATION**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex:  Male  Female

Address: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

SSN#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_  Full Time  Part Time

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Name

SSN#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_  Full Time  Part Time

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Privacy Policy** – At Jabbergym we are committed to ensuring patient privacy and confidentiality.

**INSURANCE INFORMATION**

Who is responsible for this account? \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No If yes, please complete the following:

Secondary Company

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**ASSIGNMENT AND RELEASE** I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Jabbergym all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_



**EMERGENCY INFORMATION**

Child's Name: \_\_\_\_\_ Child's Date of Birth: \_\_\_\_\_  
Current Age: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Mom Cell: \_\_\_\_\_ Mom Work: \_\_\_\_\_  
Dad Cell: \_\_\_\_\_ Dad Work: \_\_\_\_\_  
Other Phone: \_\_\_\_\_

**Emergency Contact** *(If above caregivers are not available)*

Person 1: \_\_\_\_\_ Phone: \_\_\_\_\_  
Person 2: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_  
Seizures: \_\_\_\_\_  
Food Sensitivities: \_\_\_\_\_  
Other Health Issues: \_\_\_\_\_  
Primary Doctor Information: \_\_\_\_\_  
Hospital Preference: \_\_\_\_\_

It is the policy at Jabbergym that all Parents/Caregivers stay on site during the time of their child's session. However, if in any case the parent/caregiver is not available, Jabbergym requests the right to make medical decisions in their absence.

Please sign this form authorizing Jabbergym employees to make medical decisions for your child, up to and including calling 911, in your absence.

\_\_\_\_\_  
Parent/Caregiver Signature Date

Thank You,

Dayna Thomas, M.S. CCC-SLP  
CEO, Jabbergym



## CANCELLATION POLICY

It is very important that therapy cancellations be given at least 24 hours in advance.

We understand that children can get sick, and 24-hour notice is not always possible. In these cases, it is the responsibility of the family to contact the office as soon as possible.

**A Cancellation is giving notice at least 24 hours before the day of the appointment.**

**A No-Show is canceling less than 24 hours of the day of the scheduled appointment or not calling at all.**

Please note that clients will be terminated from therapy with Jabbergym in the case of three (3) no-shows or frequent cancellations in a six month period.

I, \_\_\_\_\_, parent of \_\_\_\_\_ have read and understand the Jabbergym Policy on Cancellations and No-Shows.

\_\_\_\_\_  
Signature

Thank you for your cooperation!

Dayna Thomas

Dayna Thomas, M.S. CCC-SLP  
Owner, Jabbergym



## COMMON ROOM USE

Jabbergym encourages parents and/or caregivers to participate in Speech Language, Occupational, and Physical Therapy sessions as a means to generalize skills learned in the clinic environment to the home environment.

As our clinic is set up with individual therapy rooms and a sensory gym including swings, trampolines, ramps, sensory bins, and a dramatic play area, children may interact with other children and/or caregivers when sharing this common area.

As confidentiality for clients is important to Jabbergym, we are asking for your written permission to allow your child to interact in a common room with other children and/or adults. If this is not an acceptable option, private sessions can be accommodated.

If there are questions about this policy, please feel free to call Dayna Thomas, Owner, at (916) 771-8255.

I, \_\_\_\_\_, parent of \_\_\_\_\_ understand and allow my child to participate in Jabbergym therapy sessions with other children and/or their families in a common room as determined appropriate by the child's therapist.

OR

\_\_\_\_ I choose to have my child participate in sessions private from other children/caregivers.



## **PARENT/CAREGIVER PARTICIPATION/SITE POLICY**

It is Jabbergym's POLICY that parents/caregivers remain on-site during intervention sessions.

Additionally, research shows that family participation in a child's education improves skill development and generalization. We encourage and invite all parents/caregivers to participate in your child's session. With your interaction and participation, Jabbergym professionals are better able to explain progress, discuss rationale for therapy techniques and establish a solid professional relationship.

I understand that it is required that a parent/caregiver remain on-site during my child's intervention sessions at Jabbergym.

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Parent/Caregiver Signature

Date

Thank You,

Dayna Thomas, M.S. CCC-SLP  
CEO, Jabbergym



**CONSENT TO SHARE**

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

I give permission by way of my signature to all the agencies or individuals I have listed below to share important medical, educational, developmental, social, and psychological information regarding my child. I understand the information will be used to coordinate and plan services for my child. Confidentiality and privacy will be maintained according to the education code, section 49069; California Welfare Institute Code, Section 4514. I understand I have the right to write to any of the agencies listed withdrawing my permission at any time. This consent form will be in effect for the duration of your child’s treatment with Jabbergym.

**Release/Exchange of Information**

Please list any other person/agency that has been involved in evaluating the client (Pediatrician & Health Care Provider, Speech Language Pathologist, Occupational Therapist, Physical Therapist, Child Development Specialist, Neurologist, Developmental Pediatrician, ENT, Psychologist, Alta California Regional Center, Department of Social Services, and Local School Districts)

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\_\_\_\_\_  
Signature Parent/Guardian Date

## **SICK POLICY**

To ensure the health of our clients and therapists at Jabbergym we ask that our clients refer to our Illness Cancellation Policy to determine when it is necessary to cancel your child's therapy session due to illness.

### **CANCEL THERAPY IF YOUR CHILD HAS.....**

- Fever of 100° or higher  
Your child can return to therapy when their temperature has been normal, 98.6°,  
For 24 hours or longer.
- Vomiting or Diarrhea  
Your child can return to therapy when it has been 24 hours or longer since their  
last episode of vomiting or diarrhea.
- Rash-Always check with your physician before bringing your child to therapy with a rash.
- Head Lice-Your child should receive adequate treatment with all nits (eggs) removed from  
hair before returning to therapy.
- Chicken Pox-All pox must be crusted over and dry before returning to therapy.
- Eye Infection- eye infection is thick mucus/puss or unknown irritation in their eyes.
- Strep Throat/Sore Throat with fever or swollen glands.
- Cough/Cold- including a runny nose and/or a productive cough.
- If your child is home from daycare or school due to illness they should not attend their  
therapy appointment that day.





## **GRIEVANCE PROCEDURE**

Work related problems can arise at any place of business. At Jabbergym we hope that our employees and clients will try to reconcile differences on an individual basis. Should this not be possible, to resolve a problem quickly and fairly, Jabbergym has developed a grievance procedure using the following steps:

1. If you have a problem or concern, please notify the employees direct supervisor immediately. Most issues can be settled promptly. The supervisor shall respond in writing or email within five (5) business days of meeting with you.
2. If the problem is not resolved to your satisfaction you may go to Dayna Thomas, CEO of Jabbergym, and verbally explain the issue to her; or you may instead submit the problem to her in writing. This step should be taken within five (5) business days after the supervisor has given his/her decision or after the incident giving rise to your grievance, whichever is later. If the circumstances require it, the [previously identified official] will conduct an investigation.

Families have the right to address complaints to service coordinators at the Regional Center and ultimately to the Department of Developmental Services (DDS), if complaints are not resolved at the vendor/family level.

### **Contact Information:**

**Dayna Thomas, CEO**  
**151 N. Sunrise Ave., Suite 1105**  
**Roseville, CA 95661**

**Phone: (916) 771-8255**  
**Email: [learntotalk@jabbergym.com](mailto:learntotalk@jabbergym.com)**

**151 N. Sunrise, Suite 151, Roseville, CA 95661**  
**Phone: (916) 771-8255 Fax: (916) 771-8211**  
**Email: [learntotalk@jabbergym.com](mailto:learntotalk@jabbergym.com)**