Full Spectrum Pediatric Therapy

Pediatric Occupational & Physical Therapy
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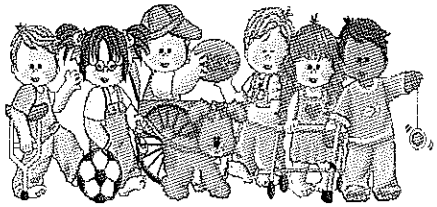

"Big Help for Little People"

DATE: _____

PATIENT INSURANCE & MEDICAL INFORMATION

****** PLEASE FILL-OUT FORM COMPLETELY...DO NOT LEAVE ANYTHING BLANK* *****

FULL NAME: _____ **DOB:** _____ **SS#:** _____

HOME PH#: _____ **CELL PH#:** _____ **WK PH#:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

EMAIL ADDRESS: _____ **SEX: M/F**

Is your child covered by MEDICAL INSURANCE? Yes No Is it Obamacare? Yes No

Who is your child's insurance under? Child Father Mother Other: _____

PRIMARY INSURANCE: _____	**SECONDARY INSUR:** _____
POLICY#/GROUP ID#: _____	**POLICY#/GROUP ID#:** _____
EFFECTIVE DATE: _____	**EFFECTIVE DATE:** _____
SPONSOR SS#: _____	**SPONSOR SS#:** _____
NAME OF INSURED (if not child): _____	**NAME OF INSURED (if not child):** _____
RELATIONSHIP: _____	**RELATIONSHIP:** _____

What therapy services has your child been referred for: OCCUPATIONAL THERAPY PHYSICAL THERAPY

Has your child been given a diagnosis: Yes No

Diagnosis: _____ **Date received Diagnosis:** _____

Please tell us the reason for your child's visit. What are your concerns? _____

_____

_____

PCP/PEDIATRICIAN: _____ **CLINIC:** _____

PCP PHONE #: _____ **ADDRESS:** _____

If you or your child is being seen at ***Blanchfield Community Army Hospital***, please indicate the clinic you are assigned to:

_____

Is your child being seen by any *other physician(s) and/or specialists* regarding their condition: YES NO

If yes, please list: _____

IN CASE OF EMERGENCY, OTHER THAN YOURSELF, PLEASE LIST WHO WE SHOULD CONTACT:

NAME: _____ RELATIONSHIP: _____

PHONE #: _____ OTHER PHONE #: _____

****

FATHER'S NAME: _____ **SS#:** _____

FATHER'S DOB: _____ **EMPLOYER:** _____

HOME PH#:_____**CELL PH#:**_____**WK PH#:**_____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

MOTHER'S NAME: _____ **SS#:** _____

MOTHER'S DOB: _____ **EMPLOYER:** _____

HOME PH#:_____**CELL PH#:**_____**WK PH#:**_____

ADDRESS: _____

CITY: _____**STATE:** _____**ZIP:** _____

If parents are divorced or separated, who has legal custody of patient/child?
( ) both parents ( ) father ( ) mother ( ) state ( ) grandparent: _____ ( ) other:_____

FOSTER PARENT/GUARDIAN'S NAME: _____SS#: _____

HOME PH#:_____CELL PH#:_____WK PH#:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Is your child assigned a Case Worker: YES NO IF YES,

Name: _____ Phone#: _____

Please initial the following:

_____ **PERMISSION TO PROVIDE TREATMENT FOR YOUR CHILD:** I authorize Full Spectrum Pediatric Therapy to provide therapy services as prescribed by my child's physician and will be continued as ordered by my child's physician. I authorize Full Spectrum Pediatric Therapy to contact, exchange, and/or discuss my child's medical history with all persons involved in providing professional services for my child.

_____ I acknowledge I understand and have received a copy of Full Spectrum Pediatric Therapy's Cancellation /No Show policy.

There will be a $40 NO SHOW/NO CALL FEE FOR EACH MISSED APPOINTMENT.

_____ I have received a copy or read Full Spectrum Pediatric Therapy's privacy and security policies and procedures.

_____ I authorize Full Spectrum Pediatric Therapy to release medical information about my child to my physician, my medical insurance company(s), Social Security Administration, its intermediaries, or carriers, and/or any information needed to bill your insurance for payment of medical benefits for services rendered at this facility. I request payment of authorized benefits be made on my behalf to Full Spectrum Pediatric Therapy, Inc.
I understand I am fully responsible for amount not paid or covered by my medical insurance to include, but not limited to co-payments, co-insurance payments, deductibles, cost-shares, legal fees, and collection fees.

_____ ***I understand if my insurance coverage changes, it is my responsibility to contact Full Spectrum Pediatric Therapy immediately of the changes. If Full Spectrum Pediatric Therapy is not notified of any changes I will be held responsible for ALL charges incurred.***

****

I, _____, hereby authorize Full Spectrum Pediatric Therapy to give and/or communicate information regarding my child's medical condition, evaluations, progress summaries or history to the following individuals:

SPOUSE: YES NO NAME: _____

SIGNFICIANCT OTHER: YES NO NAME: _____

ATTORNEY: YES NO NAME: _____

BIOLOGICAL PARENT (S): YES NO NAME: _____

OTHER: YES NO NAME: _____

Full Spectrum Pediatric Therapy has my permission to leave a message on my answering machine regarding my child:

APPOINTMENT TIME: YES NO
EVALUATION RESULTS: YES NO
ANY OTHER INFO REGARDING MY CHILD'S HEALTH: YES NO

I understand I may revoke this consent at any time by giving written notice Full Spectrum Pediatric Therapy.

PARENT'S/GUARDIAN'S NAME providing the above information:

(please print) _____

SIGNATURE: _____ DATE: _____
PATIENT / PARENT / LEGAL GUARDIAN

Therapy Intake Form

Please complete the following information for the purpose of completing a thorough evaluation with your child. Depending on your child's abilities, some questions may not be applicable.

General Information:

Patient Name: _____ DOB: _____ SEX: F M

Nickname: _____ Referred by: _____

Concern:

When did you first have concerns about your child? _____

_____

What made you concerned? _____

_____

What strategies or techniques have you been trying independently? _____

_____

What specific skills would you like your child to achieve in therapy? _____

_____

Mother's Health During Pregnancy:

1. Is this your natural, adopted, or stepchild: _____
2. Did the mother experience any infections, illnesses or injuries during the pregnancy? _____

   _____
3. Did the mother receive any medication(s) during her pregnancy? Yes No _____
4. Did mother experience any complications during labor and/or delivery? Yes No _____

   _____
5. Was your child born.... ____Full-term ____Pre-mature, how many weeks? _____
6. Delivery by..... Natural delivery ____C-section ____Forceps ____Breech ____Other_____
7. Child's birth weight: _____ Length: _____
8. Did your child have any birth injuries, complications? Yes No _____

   _____
9. Did your child require intensive care (NICU)? Yes No Please explain: _____

   _____
10. Did your child receive treatment for jaundice? Yes No If yes, what type of treatment and for how long?_____

    _____
11. Did your child require a ventilator? Yes No If yes, please explain:_____
12. How long was your child hospitalized after birth? _____

13. Please check all that apply to your child as an infant or is currently exhibiting:

____ fussier more than normal	____poor sleeper	____ easy to satisfy	____difficult to satisfy
____difficulty with sucking/nursing	____poor eater	____disliked being held	____enjoyed being held
____disliked to be "rocked" or swing	____good eater	____good sleeper	____had/has reflux
____enjoyed rocking/swing	____"overly" sensitive to noises		

____resisted certain positions: _____

____other, please explain:_____

Child's General Milestones: *At what age did your child.....*

Roll over: _____ *Exhibit head control:* _____ *Sit alone:* _____ *Crawl on hands & knees:* _____

Pull up on furniture: _____ *Walked unassisted:* _____ *Held bottle independently:* _____

Fed self finger foods: _____ *Used spoon/fork to feed self:* _____ *Drink from cup independently:* _____

Spoke first word: _____ *Put 2 or more words together:* _____ *Spoke first sentence:* _____

Toilet trained: _____ *Able to remove clothes:* _____ *Able to dress self:* _____

Ride a tricycle: _____ *Bicycle:* _____ *Catch a ball:* _____ *Kick a ball:* _____

1. Does your child have any unusual sleeping problems or habits?_____
2. Tolerate clothing textures?_____
3. Current feeding issues? (ex: texture, taste, temperature, gagging)_____
4. Does your child have any difficulty: Chewing?_____Swallowing?_____Excessive drooling?_____
5. Does your child fall or lose balance easily or seem awkward or uncoordinated?_____
6. Does your child engage in eye contact during communication? YES NO SOMETIMES
7. When given a choice, does your child prefer to play alone or with others? ALONE OTHERS
8. How does your child interact with others? (Shy, cooperative, aggressive, aloof, etc) _____
9. Does your child experience any specific challenges in school? (please explain)_____
10. What are some of your child's favorite toys/interests/hobbies?_____

Medical History:

Has your child had any of the following:

	Date/Age		Date/Age		
Chicken Pox	_____	*Measles*	_____	*Dehydration*	_____
Asthma	_____	*Hyperactivity*	_____	*Poor Attention*	_____
Encephalitis	_____	*Meningitis*	_____	*Unconsciousness*	_____
Head Injuries	_____	*Ear Infections*	_____	*Behavioral Problems*	_____
Emotional Problems	_____	*Bipolar or mood disorder*	_____		

Dyslexia, learning or academic problems _____

Seizures _____ *grand mal* _____ *silent seizures* _____ *petit mal* _____

Allergies (food, latex, medications,etc) *YES NO Please List:* _____

Immunizations up to date: YES NO If no, please explain: _____

Congenital Abnormalities: YES NO If yes, please explain: _____

Surgeries: YES NO If yes, please list date, type of surgery, and physician:

_____

_____

Has your child's hearing been tested: YES NO *Date/Results:* _____

Has your child's vision been tested: YES NO *Date/Results:* _____

Does your child wear casts, AFO's, braces, etc: _____

Does your child have or had any diseases or Major illnesses? YES NO Please explain: _____

Any other medical conditions not mentioned: _____

Previous Evaluations/therapy/exams:

___ Occupational Therapy? Dates: _____ Provider: _____

___ Physical Therapy? Dates: _____ Provider: _____

___ Speech Therapy? Dates: _____ Provider: _____

___ Early Intervention? Dates: _____ Provider: _____

___ Feeding Therapy? Dates: _____ Provider: _____

___ Psychological Evaluation? Dates: _____ Provider: _____

Findings: _____

___ Psychiatric Evaluation? Dates: _____ Provider: _____

Findings: _____

___ Neurological Evaluation? Dates: _____ Provider: _____

Findings: _____

___ Orthopedic Exam? Dates: _____ Provider: _____

Findings: _____

___ Orthotic or prosthetic fitting? Dates: _____ Provider: _____

Results/Type of orthotic: _____

___ MRI Dates: _____ Provider: _____

Findings: _____

___ CT-scan? Dates: _____ Provider: _____

Findings: _____

___ Swallow Study? Dates: _____ Provider: _____

Findings: _____

___ Sleep Study? Dates: _____ Provider: _____

Findings: _____

___ Hospitalization? Dates: _____ Provider: _____

Please explain: _____

Medications:

Is your child taking any medications at this time? **PLEASE LIST**

_____ DOSEAGE: _____ FOR? _____

_____ DOSEAGE: _____ FOR? _____

_____ DOSEAGE: _____ FOR? _____

_____ DOSEAGE: _____ FOR? _____

Emotional History & Behavior:

Does your child have any precautions/problems we should be aware of? YES NO please explain:_____

_____

Is your child primarily responsive: to people? _____ Objects? _____

Is your child ***especially*** alert to: movement?_____Noises?_____Touch?_____

Is your child's behavior consistent from day to day? _____

How does your child do with peers? _____

When placed under pressure or tension, is there any pattern of behavior, such as temper tantrums, thumb sucking, nail biting, etc? _____

How is your child doing in school academically?_____

Does your child have difficulty with daily tasks such as chores, self-care, homework, etc?_____

_____

Please give a brief description of your child's "personality". Please include your child's strengths & weaknesses:_____

_____

_____

Family/Social History:

With whom does your child live with? ( ) Both parents ( ) Mother ( ) Father

( ) Grandparents -maternal or paternal? ( ) Guardian: _____

If parents are divorced / separated who has legal custody? _____

How many siblings does your child have and their ages:

_____ _____

_____ _____

_____ _____

What is your child's primary language? _____ Does your family speak any other language at home?_____

_____

Does your child attend daycare or preschool? YES NO Name of Program/school:_____

What grade is school is your child? _____Name of School:_____ Teacher:_____

PLEASE LIST YOUR CONCERNS & GOALS REGARDING YOUR CHILD:

	CONCERNS	GOALS
GROSS MOTOR & BALANCE		
FINE MOTOR SKILLS/HANDWRITING		
VISUAL		

	CONCERNS	GOALS
SOCIAL/EMOTIONAL/BEHAVIOR		
COGNITIVE		
COMMUNICATION		
SELF-HELP SKILLS		
FEEDING SKILLS		
SENSORY PROCESSING		
OTHER:		

Thank you for taking the time to fill out all of the information! If you have any questions or concerns regarding your child's therapy or welfare, please feel free to speak with your therapist.