MEDICAL HISTORY					
Has your child had any of the following: (please check)					
Adenoidectomy		Frequent Ear Infections		Strabismus	
Allergies		Gastric Reflux		Tonsillectomy	
Asthma/ Breathing difficulties		Head Trauma/ Concussion		Tubes in Ears	
Broken Bones		Hearing Impairment		Vision Problems	
Cleft/Lip Palate		Nearsighted/Farsighted			
Constipation		Seizures			
Does child wear glasses? Yes ☐ No ☐					
Does child wear hearing aids? Yes ☐ No ☐					

PAIN SCALE
Rate child's pain on a scale of 0 (no pain) - 10 (worst pain):
Location of pain:

Please list/describe any additional health concerns:

____

____

PREVIOUS HOSPITALIZATIONS		
Date Hospitalized	Name of Hospital	Reason for Hospitalization
PREVIOUS SURGICAL PROCEDURES		
Date Hospitalized	Name of Hospital	Surgical Procedures Performed
CURRENT & PREVIOUS MEDICAL DIAGNOSES (please list)		

Most Recent Vision Exam	Date:	Results:
Most Recent Hearing Exam	Date:	Results:

PEDIATRIC
THERAPY ASSOCIATES

ALLERGIES	
Medication	Reaction
Foods	Reaction
Other	Reaction

MEDICATIONS (list all prescription and over-the-counter medications)

PAST THERAPY SERVICES			
Has your child previously received therapy?	Yes ☐ No ☐		
If yes, what type?			
When?		Where?	

CURRENT THERAPY SERVICES			
Therapy	Yes ☐ No ☐		
If yes, what type?			
When?		Where?	

MEDICAL EQUIPMENT USED (please check)			
Wheelchair		Crutches	
Braces		Communication Device If yes, what kind:	
Walker		Feeding Tube/Pump	
Other:			

When did your child first:					
Roll over		Throw a ball		Reach for objects	
Crawl		Kick a ball		Say 1st word	
Sit alone		Drink from open cup		Use 2-word phrases	
Walk alone		Use a spoon/fork		Use sentences	
Use stairs		Toilet train		Follow commands	
Jump		Ride a bike		Point to pictures	

CURRENT CONCERNS (please check)			
Attention		Strength/Endurance	
Behavior		Self-calming/control/emotional regulation	
Clumsiness/Falling/Balance		Sleeping	
Communication		Social skills	
Coordination		Toileting	
Feeding			

Please list any additional concerns:

____

Does your child display any of the following behaviors? (please check)					
Temper Tantrums		Anxiety		Self-injurious behavior	
Poor self-control/ emotional regulation		Repetitive behaviors Describe:		Depression/ suicidal thoughts	
Eloping/ running away		Poor eye contact		Aggression	

Does your child display any other behavioral issues or atypical behavior?

____

DIET HISTORY					
Does your child eat a typical diet?	Yes	No	Problems chewing/swallowing? Feeding concerns?	Yes	No
Please list any dietary restrictions					

HEALTH CARE PROVIDERS		
Pediatrician		
Name:	Phone #:	
Please list any other doctors your child sees regularly		
Name:	Phone #:	Specialty:
Name:	Phone #:	Specialty:

EDUCATION	
School & grade	
IEP	Yes ☐ No ☐
Type of Classroom (ex. small group, ESE/self contatined, typical):	
Has your child ever repeated a grade?	

CONSENT FOR MEDICAL TREATMENT OF A MINOR

I the undersigned, the patient or the patient's duty representative, do hereby voluntarily consent to and authorize care encompassing all diagnostic and therapeutic treatments considered necessary in the judgment of the care provider for my minor child. I understand that the treatment plan may change, and if so, these changes will be discussed with me. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or therapies my child may receive. This form has been fully explained to me and I certify that I understand and accept its contents as noted.

Parent/Guardian Signature: ______________________

Print Name: ________________________________

Date: ____________________________________

RECEIPT OF NOTICE OF INFORMATION PRACTICES

Please initial and sign

_____ Initial — By initialing here, I acknowledge receipt of Pediatric Therapy Associates Care Notice of Informational Practices.

_____ Initial — I understand that my health information is confidential but may be used or released in accordance to federal and state law for purposes of treatment, payment or health care operations, including, but not limited to, outcomes assessment, quality assurance, business planning/improvement activities, service providers on my evaluation and/or treatment team, other treating healthcare providers involved in my care, utilization review organizations or agencies that provide managed care services for my insurance benefits.

_____ Initial — I agree to disclosure of the patient's health information to a family member or close personal friend who is involved in their care.

The following individuals are authorized to discuss private health information regarding my child: ____

____

Parent/Guardian Signature: ______________________

Print Name: ______________________________

Date: ________________________________

PEDIATRIC
THERAPY ASSOCIATES

DATE		
PATIENTS NAME		
Last:	First:	Middle:
Birthdate:	Sex: Male ☐ Female ☐	
Street Address:		
City:	State:	Zip Code:
Phone #:		

CHILD'S RACE/ETHNIC GROUP					
Caucasian		Hispanic		African American	
Native American		Asian or Pacific Islander		Other	
Preferred language for discussing health care information				English	Other
If other, which language?					
What is the primary language spoken at home?					
~~Do you require interpreter services?~~					

PARENT/CAREGIVER NAME	**PARENT/CAREGIVER NAME**
Biological ☐ Step ☐ Adoptive ☐ Foster ☐ Other ☐	Biological ☐ Step ☐ Adoptive ☐ Foster ☐ Other ☐
Last: First:	Last: ~~First~~
Relationship to child:	Relationship to child:
Address: (if different than child)	Address: (if different than child)
City: State: Zip Code:	City: State: Zip Code:
Phone #:	Phone #:
Email:	Email:
Occupation:	Occupation:

Parents are:	Married ☐	Separated ☐	Divorced ☐	Never Married ☐
Does patient live with both biological parents?			Yes ☐	No ☐
If no, who does the child live with?				
Is child adopted?	Yes ☐	No ☐		

SIBLINGS			
Name	**Biological or Step**	**Age**	**Medical or Academic Problems**

EMERGENCY CONTACT	EMERGENCY CONTACT
Name:	Name:
Relationship:	Relationship:
Phone #:	Phone #:

INSURANCE			
Primary Insurance Company:			
Insurance Co. Phone #:		Insured Name:	
Policy #:		Group #:	
Secondary Insurance Company:			
Insurance Co. Phone #:		Insured Name:	
Policy #:		Group #:	

PERINATAL HISTORY
Mothers age at delivery:
Complications of pregnancy
weeks at delivery
Complications of labor and/or delivery
Birth Weight:
Delivery: Vaginal ☐ Cesarean ☐

NEONATAL (BIRTH) HISTORY		
Hospitalized in NICU	Yes ☐ How long?	No ☐
Complications after birth?		
Other medical problems in infancy:		

FINANCIAL & ATTENDANCE POLICIES

Please initial and sign

_____ 1. Financial Policy
Initial

I understand that in consideration of the services rendered to the patient, I am directly responsible for payment of services rendered at Pediatric Therapy Associates. I understand Pediatric Therapy Associates will obtain a verbal approval from my insurance company to verify benefits prior to treatment. Verbal approval is not a guarantee of payment. A written explanation of payment is the only guarantee of coverage for services rendered. If the insurance carrier should pay a claim in error, the balance due for services is responsible of the guarantor. Payment of deductibles or co-payments is due in full at the time of service.

_____ 2. Cancellation Policy
Initial

A 24-hour notice of cancellation is required for all scheduled appointments. A fee of $50.00 will be applied for all cancellations made without 24-hours notice. If your child is sick, we require cancellation no later than 8:00 am the day of the scheduled appointment. This notice is necessary so that cancelled therapy times can be utilized for other clients in need of treatment. We thank you for understanding in this matter.

_____ 3. Returned check policy
Initial

A fee of $25.00 will be charged for any returned check. Once a check is returned, credit/debit card payment or cash payment will be required.

_____ 4. Non-Compliance
Initial

Non-compliance with treatment and appointments may result in discharge.

_____ 5. Attendance Policy
Initial

If you are often late for appointments by at least 15 minutes, we have the right to reschedule your appointment time due to the limitations of the clinic.

_____ 6. Appointment Reminders
Initial

Pediatric Therapy Associates utilizes an appointment reminder system to alert you of upcoming appointments. Reminders may be sent by text. By initialing, I agree to receive appointment reminders.

By signing, I agree to the above policies.

Parent/Guardian Signature: ____________________
Print Name: ____________________
Date: ____________________