Play. Learn. Grow.

Patient Identification

Last Name ______ First Name ______ Middle Name ______ Gender ______

Date of Birth ______ Age ______ Years - Months ______ Social Security Number ______

Home Address ______ City ______ State ______ Zip Code ______

Email Address ______ Primary Contact Phone Number ______

Child's Pediatrician ______ Pediatrician Phone Number ______ Name of Pediatric Office/ City, State ______

Would you like to receive text messages regarding your child's appointment? YES NO ______ Text Phone Number

Patient Family Information

Parent/Guardian Name ______ Relationship to Child ______ Contact Phone Number ______

Parent/Guardian Name ______ Relationship to Child ______ Contact Phone Number ______

Child lives with (check one): ☐ Birth Parents ☐ Foster Parents ☐ Adoptive Parents ☐ One Parent ☐ Other

Other Children in the Family: Name Age Gender

______

______

______

Is there a language other than English spoken in the home? YES NO If yes, which one? ______

What language does your child speak at home? ______

Insurance Information

Primary Insurance Carrier ______ Policy Holder's Name ______ Policy Holder's DOB ______ Policy # ______ Group # ______

Secondary Insurance Provider ______ Policy Holder's Name ______ Policy Holder's DOB ______ Policy # ______ Group # ______

Why are we seeing you today?

Reason for Referral (Check all boxes that apply.) Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐

What are your Pediatrician's Concerns?: ____

What are YOUR main concerns regarding your child's development?____________________________

____

What are some goals you have for your child? ____

Medical Case History

Please help our therapist get ready to evaluate your child. We appreciate all the information you can give us. ***We're here to help***!

1.Prenatal and Birth History:

Child was born: Full Term ________ Premature __________ How many weeks premature? _________

Delivery: Vaginal _________ Forceps _________ Vacuum _________ C-section ___________

Birth Weight: ____________________

Did you have any complications? ____

Was your child placed in the Intensive Care Unit? __________ If so, How long? ______________________

Please describe any other prenatal medical problems or complications at birth: ______________________

2. Medical History:

Does your child have any allergies? YES NO If yes, what: ______________________________

Are they taking any medications? YES NO If yes, what: ______________________________

Please list any hospital stays or surgeries including approximate ages: ______________________

Current or Ongoing Health Concerns: ____

Special equipment your child uses: Splints ________ Braces_________ Adaptive Utensils_________ Wheel Chair_____

History of Ear Infections: YES NO Date of Last Hearing Screening: ______________________

Date of Last Vision Screening: ______________________

Please check all that apply to your child:

___ Hearing Aids ___Hearing Difficulty ___Ear Tubes ___Chronic Ear Infections ____Surgeries

___Vision Difficulty ___Vision Testing ___Glasses ___G-Tube ___ C-Line _____Reflux

___ Seizures ___Asthma ___Allergies ___History of Broken Bones: ____________

___ Neurological Condition ___Dietary Restrictions ___Psychological Disorder ____Pain ____Diabetes

Explanations of Any Medical Conditions:

____

3. Developmental Milestones: (mark approximate month)

Rolled Over _______ Babbled ________ Said First Word _________ Sat Alone _______ Crawled __________

Drank from a Cup ________ Walked Alone _________ Pulled to Stand ___________ Used a Spoon ________

Responded to Name ________ Points and Names Objects ____________ Toilet Trained ___________ Dressed Self: _______

Current Physical Limitations: ____

What is your child's hand dominance? RIGHT LEFT BOTH

4. School History/Previous Therapy

Is your child currently receiving therapy in a school? YES NO Is your child on an IEP? YES NO

Name of school currently attending and grade: ___________________________________

Special services received in school (include teacher/therapist if known):

OT_______ PT ______ Speech _______ Special Education ________ Behavior Intervention _______

Does your child's teacher have concerns with your child's development in any of the following areas?

Motor Skills _______ Social Abilities _______ Self-Help Skills ________ Learning Abilities _________ Speech _________

Has your child ever repeated a grade? _____________________________ If yes, when: _______________________________

School History including Pre-school, SoonerStart, and other Early Intervention: ____

Extracurricular Activities: ____

Has your child ever had therapy outside of school? YES NO
Has your child ever received an evaluation by a SLP, PT, or OT before? YES NO If yes, when: ______________________

Previous Therapy ____ ______________________________
Name of Clinic/Therapist Dates of Therapy (from-to)

5. Behavior

Please check any of the following that apply to your child:

____ Cries often
____ Dislikes hair brushing
____ Clumsy
____ Weak Muscles
____ Rocks self
____ Craves jumping/crash play
____ Trouble with directions
____Stubborn
____ Self-Abusive behavior
____ Separation difficulties
____ Inappropriate behavior
____ Grinds teeth
____ Seems to be "on the go"
____ Poor attention span
____ Trouble transitioning
____ Picky eater
____ Trouble attending to task
____ Dislikes playground
____Willing to try new activities
____ Attentive
____ Restless
____ Impulsive/easily frustrated
____ Sensitive to sounds
____ Avoids touch from others
____ Dislikes tooth brushing
____ Anxious
____Sensitive to light
____ Mouths objects
____Has trouble playing with others
____ Poor eye contact
____ Cooperative
____ Withdrawn
____ Prefers playing alone

Does your child have sleeping difficulties? YES NO Explain: ____

____ Snoring _____ Difficulty falling asleep _____Difficulty staying asleep _____Restless _____Apnea

What do you see as your child's most difficult problem at home or at school? ____________________________________

____

Do you feel like your child is frustrated or aware of any speech/ and or motor difficulties he or she may have? ___________

____

Would you like for us to know anything else about your child? ____

____

Likes? ______________________________________ Dislikes?_____________________________________

How does your child communicate his/her wants or needs? ____ Cries _____Points ____ Uses Short Sentences

____Uses Long Sentences _____Uses One Word at a Time ____Makes Sounds

6. Feeding History

Early Feeding: (Circle all that apply) Bottle Breast Both Until what age: ____________________

Any difficulties with early feeding: ____

Please check any problems that your child might be having with feeding/swallowing:

___Gagging ___Choking ___Reflux/GERD ___Excessive Drooling

___Food Stuffing ___Pocketing/Holding ___Puree foods ___Solid Foods

___Cup Drinking ___Straw Drinking ___Self-Feeding ___Picky Eater

Please describe checked items: ____

Any nutritional concerns? Is your child eating a good variety of foods? ____

Food preferences that you've noticed? (Likes/Dislikes, Tastes, Textures) ____

Additional Comments: ____

7. Speech Therapy (ONLY)

Tell us about babbling/cooing behavior? ____

Does it seem normal? YES NO Would you say it's a LITTLE or A LOT?

First words, was it before 18 months _________ or after 18 months __________?

When did your child begin to combine words into simple phrases or sentences? __________________

Please give us some examples of common sentences your child says: ____

____

Is your child easy to understand by family members or are you constantly acting as the interpreter? ______________________

What percentage of your child's speech do you understand? _______________

Does your child...

____ Repeat sounds, words or phrases over and over ____Understand what you are saying

____ Retrieve/point to common objects upon request (ball, cup, shoe) ____Follow simple directions ("Shut the door.")

____ Respond correctly to yes/no questions ____Use body language to communicate

Authorization and Consent to Treat

I hereby authorize and provide permission for TheraPlay Pediatrics to receive information from and/or speak to my child's doctor, teachers, and any other professionals currently working with my child in regards to pertinent information, current treatment goals, and progress being made.

HIPPA Consent

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment , to obtain payment from insurance companies, and for health care operations such as quality reviews. I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices of the practice/clinic. I understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my request restriction, they must follow the restrictions(s). I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Cancellation/No Show Policy-Please call 24 hours in advance to cancel.

I understand that TheraPlay Pediatrics reserves the right to charge $25 for treatments that are not cancelled within 24 hours of the scheduled appointment time. I understand that 3 unexcused no shows/unexcused cancellations will result in a discharge from TheraPlay Pediatrics and a letter will be sent to my child's primary care physician(PCP).

Patient/Insurance Authorization

I authorize for all insurance payments to be made directly to TheraPlay Pediatrics for therapy services rendered. I acknowledge that I am financially responsible for all charges not covered by this assignment. I further acknowledge that my insurance company may limit therapy benefits. I will be responsible for all charges accrued if my insurance denies serves.

I have read and fully understand the above consent for treatment, release of medical information, and payment/insurance authorization. I request that payment under the medical insurance program be made to the provider names below on any bills for services furnished to me. I authorize the below-name provider to release to the Social Security Administration, its intermediaries or carrier's information needed for the claim or any related claim. I acknowledge that I have read and understand the Authorization. I further permit a copy of this authorization to be used in the place of the original.

Provider's Name: TheraPlay Pediatrics
Provider's Address: 1809 Commons Circle Suite B, Yukon, OK 73099

____ ____________________
Please Print (Parent/Guardian) Relationship to Patient

____ ____________________
Signature (Parent/Guardian) Date