Play. Learn. Grow.

OPTC Oklahoma Pediatric Therapy Center

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

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 OPTC 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, treatment goals, and progress being made. Agree Initial ___________

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. Agree Initial __________

Insurance/ Patient Payment Requirements

I authorize for all insurance payments to be made directly to Oklahoma Pediatric Therapy Center, OPTC, for therapy services rendered. **I acknowledge that I am financially responsible for all charges not covered by my insurance provider**. I further acknowledge that my insurance company may limit therapy benefits, and I am responsible for understanding those benefits at all times. As a courtesy, OPTC tries to check coverage. However, the patient is responsible to check these benefits and coverage and fully understand benefits allowed. I will be responsible for all charges accrued if my insurance denies service. I understand that my copay will be paid every time I see a therapist. I also understand that my bill cannot exceed $350 at any time or my child's name will return to the waiting list until outstanding bill is paid and a new time slot opens up. The patient will be responsible to pay a $25 fee for any returned checks. Agree Initial __________

Cancellation Policy

Here at OPTC, we strive to provide the best **one-on-one** care possible. The appointments you make will be reserved and planned specifically for your child. To receive the maximum benefit of treatment, it is important that you attend each of your scheduled appointments and that you arrive on time for your appointments. Providing one-on-one care to each patient requires that we do not overbook or double book our appointments. Unfortunately missed appointments result in open slots in our therapists' schedules and are a lost opportunity to help other patients. While we understand emergency situations, and times when you will have to cancel- our facility requires a **$25 fee for treatments that are not cancelled within 24 hours of the scheduled appointment time**. This fee is your responsibility and must be paid prior to your next scheduled treatment. Agree Initial ___________

Attendance Policy

Because our wait list is so long, we have a monthly attendance policy. Your therapist will keep track of your excused (running fever, throwing up, calling to cancel 24 hours before appointment time, etc.) and unexcused (forgot, non-severe weather, consistently not feeling well, vacation without calling) appointments missed. If your child has two unexcused appointments in a two month period, you will receive a written warning. **If your child misses three unexcused visits in a two month period, your child will be discharged from therapy**. A letter will be sent to your primary care physician (PCP) explaining the reason for discharge from our services. In order to resume services you will need to obtain a new referral from your PCP and reschedule. This will potentially cause a loss of your preferred time slot. We do understand there are special circumstances that can occur and we will review those carefully before making our final decision. Per treatment guidelines, once a child has not received care for greater than 60 days, we are unable to satisfy treatment goals and functional progress notes cannot be updated to the referring provider and therapy will be placed in our inactive files and a discharge summary will be sent to the referring provider. However, if at a later date services are again indicated the child may again be scheduled for active care for the necessary re-evaluation. Agree Initial ___________

I understand, and agree to these policies. ________________________________ ____________

Signed Date