# New Patient Pre-Evaluation Packet

*please complete and return this packet prior to your child's evaluation*

**Child's Name:** _____ **Child's Date of Birth:**_____

Legal Guardian (PRINT):_____

## Required Authorizations/Notices

### 1. Authorization for Evaluation and Treatment

I authorize physical therapy, speech therapy, developmental therapy, occupational therapy, orthotic equipment, and/or communication device evaluation(s) and treatment for the above said child.

_____ _____

Signature Date

### 2. Payment Authorization and Financial Agreement

I authorize payment of medical benefits to be made directly to Children's Therapy TEAM for services rendered. I agree to either fully pay or set up a payment plan and begin payment for all charges within 30 days of the receipt of my child's patient statement. I agree to be fully responsible for charges, regardless of my insurance company's coverage or lack of coverage of charges. Failure to pay outstanding balances will result in additional charges for collection and/or attorney's fees.

_____ _____

Signature Date

### 3. Notice of Treatment by Other Providers

My child has received, within the last 12 months, a therapy evaluation or therapy services from a provider outside of Children's Therapy TEAM. YES NO

☐ ☐

*If YES, what services were received/where were they received*_____

_____

### 4. Parent Handbook Notices and Policies Agreement

I acknowledge that I have been given a copy of Children's Therapy TEAM's **Parent Handbook** which includes:

- HIPAA Privacy Practice Notices
- Attendance Policies
- Sick Policies
- Inclement Weather Policy
- Sibling Policies
- Aquatic Therapy Policies
- Parent Communication Policies
- Discharge Policies

I agree to follow the guidelines and policies set forth by Children's Therapy TEAM.

_____ _____

Signature Date

### 5. Notice of Status as a Teaching Facility

I acknowledge the status of Children's Therapy TEAM as a teaching facility. Students around the region periodically observe clinic operations and treatment sessions.

_____ _____

Signature Date

### 6. Medical Consent

I authorize the administration of first aid and/or CPR, as deemed necessary by staff members of Children's Therapy TEAM. Additionally, 911 will be contacted in serious medical emergencies, as deemed necessary by employees of Children's Therapy TEAM. Employees of Children's Therapy TEAM will contact me as soon as possible to inform me of the medical emergency.

_____ _____

Signature Date

*office use only: 1/5/2017*

### 7. Communication Consent

YES NO

☐ ☐ *email*
Do you consent to use of email correspondence with Children's Therapy TEAM? This includes sharing confidential patient health information.

☐ ☐ *eNewsletters and eEvent Notices*
Would you like to receive eNewsletters and eEvent Notices from Children's Therapy TEAM?

☐ ☐ *text*
Do you consent to receiving appointment reminders and other messages from Children's Therapy TEAM through text?

☐ ☐ *voicemail*
Do you consent to receive voice mail messages from Children's Therapy TEAM?

_____ _____
Signature Date

### 8. Transportation Consent

I authorize employees of Children's Therapy TEAM to transport the said child to and from the treatment or rehab site to my home address or other designated location if the parent or transportation provider is unable to provide transportation due to an emergency.

_____ _____
Signature Date

## Required for Aquatic Therapy

### 9. Aquatic Liability Release and Assumption of Risk

I acknowledge the risks related to the use of an aquatic environment to provide therapy, particularly the risk of drowning if a therapist for any reason becomes incapacitated while providing one-on-one therapy. I understand that this risk can be minimized with careful parent/caregiver supervision as there is no lifeguard on duty.

I hereby, intending to be legally bound, for myself, my heirs, assigned executors or administrators, waive and release forever all claims for damages against Children's Therapy TEAM, its board of directors, instructors, therapists, aides, volunteers and/or employees, the pool owner, their board of directors, management, employees, aids and volunteers for any and all injuries and/or losses that I, assisting guardians, assisting caregivers and/or my son/my daughter/my ward may sustain while in the aquatic environment for therapy (or any activity) provided by and/or sponsored by Children's Therapy TEAM

_____ _____
Signature Date

## Optional Consents

### 1. Interaction with Student Clinicians under the Supervision of a Licensed Therapist

I, the legal parent/guardian of the above said child, support Children's Therapy TEAM in their role as a teaching facility. I give permission for my child to receive services rendered by a student clinician (those completing fieldwork as part of their graduate program in PT, OT, ST, or DT) under the direct supervision of a licensed therapist.

_____ _____
Signature Date

### 2. Instructional Use Authorization to Photograph/Video

I, the legal parent/guardian of the above said child, give Children's Therapy TEAM the right and privilege to photograph/video my child for educational and instructional purposes. I understand that videos and/or photographs of my child may be viewed and discussed during instructional classes (sometimes web-based), in medical journals/e-journals, in medical books/e-books and on instructional posters/e-posters.

_____ _____
Signature Date

### 3. Promotional Use Authorization to Photograph/Video

I, the legal parent/guardian of the above said child, give Children's Therapy TEAM the right and privilege to photograph/video my child for the use of developing and publicly releasing promotional information. I understand that my child's image may be viewed in the form of magazines, picture slideshows, posters, television, commercials and/or electronic media.

_____ _____
Signature Date

### 4. Authorization to Administer Medication

Please administer the following medications as needed:_____
_____
_____

**Please note the dosage and the reason for administration of the medication.*

_____ _____
Signature Date

# HIPAA Authorization

Child's Name:_____ DOB:_____

Authorization to Release or Obtain Information

I hereby authorize Children's Therapy TEAM (DBA Children's Therapy TEAM) to release or obtain my child's individually identifiable information, including contact information, information about physical or mental health, information about health care services, information about education services and information about payment for services under the circumstances described below.

Purpose *(check one or more)*

☐ at the request of the parent/guardian
☐ for Health Care Services

Release

Disclosure TO/FROM (circle one or both)_____

Disclosure TO/FROM (circle one or both)_____

*Type of information to be disclosed in oral or written form: _____

_____

_____

_____

_____

_____

*NOTE: If this authorization is used for psychotherapy notes, it may not be used for any other type of information.

I understand that:

- This authorization must be filled out completely. A copy is as valid as the original.
- Children's Therapy TEAM will not refuse to provide health care services to me, based on my refusal to authorize the use or disclosure of my child's personal health information for purposes unrelated to those health care services.
- I may revoke this authorization at any time by notifying Children's Therapy TEAM in writing, but if I do, it won't affect any actions Children's Therapy TEAM took in reliance of this authorization before I revoked it.
- Once information is released to a third party according to this authorization, Children's Therapy TEAM cannot prevent its re-disclosure.
- This authorization does not limit the ability of Children's Therapy TEAM to use or disclose my child's health information as otherwise permitted by state and federal law.

PRINT Parent/Legal Guardian's Name:_____

Parent/Legal Guardian's Signature:_____Date:_____

Expiration Date 1 year from date signed, unless an earlier date is provided here:_____

***You are entitled to a copy of this authorization form.***

# Face Sheet

Child's Name:_____ Date of Birth:_____
Today's Date: _____Evaluation Date:_____

Parent/Guardians Names: _____
Employer(s):_____

Parents' Dates of Birth:_____
Address:_____
City:_____ State:_____Zip Code: _____

Name of Emergency Contact (other than the parent): _____
Emergency Contact Phone Number:_____

**Communication Preferences:**

Please mark phone preferences as: (1) use first, (2) use as back-up, (X) do not use

_____ Home Phone Number_____
_____ Father's Employer Phone Number_____
_____ Mother's Employer Phone Number_____
_____ Father's Cell/Text Number_____
_____ Mother's Cell/Text Number_____
_____ Other Cell/Text Number_____relation:_____

Please mark email preferences as: (1) use first, (2) use as back-up, (X) do not use

_____ Mother's email address_____
_____ Father's email address_____
_____ Other email address_____relation:_____

**Physician:**

Primary Care Physician:_____Clinic:_____

**Diagnosis:**

My Child's Primary Diagnosis:_____
My Child's Secondary Diagnosis:_____
Who diagnosed your child?_____ Date of diagnosis:_____

**Primary Insurance:**

Insurance Policy Name: _____ Policy Number: _____
Group Number: _____Insured's Name:_____
Insured's DOB:_____Insured's Place of Employment:_____

**Secondary Insurance:**

Insurance Policy Name: _____ Policy Number: _____
Group Number: _____Insured's Name:_____
Insured's DOB:_____Insured's Place of Employment:_____

**Tertiary Insurance:**

Insurance Policy Name: _____ Policy Number: _____
Group Number: _____Subscriber's Name:_____
Insured's DOB:_____Insured's Place of Employment:_____

Medicaid, Tefra, and/or ARkids Number:_____

# Case History

Child's Name:_____ Date of birth:_____

Sex: male / female Child's Address:_____

Today's Date:_____

***NOTE:*** *Children's Therapy TEAM requests this information for the sole purpose of completing your evaluation. Completion of this case history is required prior to your scheduled evaluation. Failure to provide the information may result in an incomplete examination or cancellation of the assessment. If applicable, also submit or authorize TEAM to request on your behalf: a copy of recent hearing/vision test results, a copy of his/her IEP or 504, a copy of previous therapy evaluations.*

**A.** Has your child had his/her hearing and vision tested? **Yes / No**
If *yes,* where, when, and what were the results?_____
_____
_____

**B.** What services are you requesting? *(check all that apply)*

- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Physical Therapy
- ☐ Aquatic/Pool Therapy
- ☐ Developmental Therapy (only for birth to age three)
- ☐ Behavioral Consultation

**C.** Has your child participated in Occupational, Physical, Speech, ABA and/or Developmental Therapy in the past? **Yes / No**

If *yes,* please note which therapies were received, as well as their frequency?
_____
_____
_____

## D. Therapy Precautions

| Questions | YES | NO | Comments |
|---|---|---|---|
| 1. Does your child have any food allergies? | | | *Please list allergies:* |
| 2. If your child has Down Syndrome, has he/she been diagnosed with Atlantoaxial instability? | | | |
| 3. Are there any precautions not listed above that we should know about? (latex allergies, dietary restrictions, etc.) | | | *Describe:* |

## E. Family & Social History

Father's Name:_____Age:_____ Occupation:_____
Mother's Name:_____Age:_____Occupation:_____

Is the client adopted? **Yes / No** If *yes,* at what age and from where/what country was he/she adopted?_____
Who lives in the house with this child, other than the parents? Please list the names and ages of children.
_____
Have there been any instances of the following in your immediate or extended family members:

- ☐ ADHD
- ☐ Hearing Loss
- ☐ Learning Disabilities
- ☐ Stuttering
- ☐ Communication Disorders
- ☐ Autism/PDD

Are there currently any stressful situations in the home or family?_____
Is there any history of abuse?_____

## F. Pregnancy and Birth History

| Questions | YES | NO | Comments |
|---|---|---|---|
| 1. Were there any illnesses, bleeding, or other complication during this pregnancy? | | | *Describe:* |
| 2. Was this pregnancy full term? | | | If "no", what was your child's gestational age at time of delivery? |
| 3. Was labor and delivery normal? | | | *If "no" please describe:*<br><br>birth weight:_____ birth length: _____<br>*Was the birth vaginal, breech or cesarean?* |
| 4. Did the child feel stuck in one position? | | | |
| 5. Were forceps or a vacuum extractor used? | | | |
| 6. Did your child experience jaundice? | | | |
| 7. Was there a need for oxygen or respiratory assistance? | | | *Describe:* |
| 8. Were there difficulties feeding? | | | *Describe:* |
| 9. Was your child breastfed (or currently breast feeding)? | | | *If "yes", how long?*<br>*Any breastfeeding problems related to the baby's difficulty turning his/her head to nurse?* |
| 10.Did your child have sucking difficulties? | | | *Describe:* |
| 11. Does this child have biological siblings? | | | *How many siblings?*_____<br>Which pregnancy was this child?_____ |
| 12. Are there issues with sleep problems? | | | *Describe:* |

## G. Has your child had any of the illnesses, conditions and/or medical equipment below?

| Illness/ condition/ apparatus | YES | NO | Comments |
|---|---|---|---|
| 1. Meningitis | | | |
| 2. Chicken Pox | | | |
| 3. Seizures | | | |
| 4. Frequent ear infections | | | |
| 5. P.E. tubes | | | |
| 6. Excessive vomiting or reflux | | | |
| 7. Irritability/fussiness following feeding? | | | |
| 8. Swallowing difficulties (current or previous) | | | |
| 9. Cleft palate | | | |
| 10. Vision problems | | | |
| 11. Adaptive equipment | | | |

Please list current and past medications. _____
_____
_____
_____
_____

Please describe any pertinent medical condition not mentioned above (accidents, injuries, etc.).
_____
_____
_____
_____
_____

Please provide the dates and descriptions of surgical procedures (if any).
Date:_____ Surgery:_____Description:_____

Date:_____ Surgery:_____Description:_____

Date:_____ Surgery:_____Description:_____

Date:_____ Surgery:_____Description:_____

Date:_____ Surgery:_____Description:_____

Date:_____ Surgery:_____Description:_____

Date:_____ Surgery:_____Description:_____

*For additional surgeries use back as needed.*

## H. At what age did your child achieve the skills below?

| Developmental Skill | Age achieved | Not yet achieved | Comments |
|---|---|---|---|
| 1. Roll from stomach to back | | | |
| 2. Roll from back to stomach | | | |
| 3. Crawl | | | |
| 4. Cruise around furniture | | | |
| 5. Walk independently | | | |
| 6. Speak first words | | | |
| 7. Speak two word sentences | | | |
| 8. Drink from a cup | | | |
| 9. Use a spoon | | | |
| 10. Dress independently | | | |
| 11. Sit independently | | | |
| 12. Toilet trained | | | |
| 13. Toilet trained through the night | | | |

## I. Can your child display any of the physical skills below?

| Skill | YES | NO | N/A | Comments |
|---|---|---|---|---|
| 1. Jump up and down | | | | |
| 2. Hop on one foot | | | | |
| 3. Climb/descend stairs using alternate feet | | | | |
| 4. Skip | | | | |
| 5. Catch a ball | | | | |
| 6. Kick a ball | | | | |

## J. Describe your child's behavior below.

| Questions | YES | NO | N/A | Comments |
|---|---|---|---|---|
| 1. My child is overly active. | | | | |
| 2. My child is mostly quiet. | | | | |
| 3. My child talks constantly. | | | | |
| 4. My child is impulsive. | | | | |
| 5. My child is frequently irritable. | | | | |
| 6. My child is stubborn. | | | | |
| 7. My child is resistant to change. | | | | |
| 8. My child overreacts. | | | | |
| 9. My child fights frequently. | | | | |
| 10. My child is usually happy. | | | | |
| 11. My child has frequent temper tantrums. | | | | |
| 12. My child is clumsy. | | | | |
| 13. My child has difficulty separating from caregiver. | | | | |
| 14. My child has nervous habits or tics. | | | | |
| 15. My child has a poor attention span. | | | | |

| Questions | YES | NO | N/A | Comments |
|---|---|---|---|---|
| 16. My child is frustrated easily. | | | | |
| 17. My child has fears. | | | | If "*yes*", please describe. |
| 18. My child rocks himself/herself frequently. | | | | |
| 19. My child shows difficulty learning new tasks. | | | | |
| 20. My child avoids touch. | | | | |
| 21. My child craves touch. He/she seeks it out. | | | | |
| 22. My child is shy. | | | | |
| 23. My child is typically compliant. | | | | |
| 24. My child tires easily. | | | | |
| 25. My child is easily managed at home. | | | | Who manages your child best? |
| 26. My child empathizes with others' feelings easily. | | | | |
| 27. My child understands punishment and easily shows remorse. | | | | |
| 28. My child understands praise and reward. | | | | |
| 29. My child recognizes danger. | | | | |
| 30. My child is affectionate toward familiar adults. | | | | |
| 31. My child is affectionate toward strangers. | | | | |
| 32. My child has friends. | | | | |

## K. Describe your child's communication below.

| Communication skill | YES | NO | N/A | Comments |
|---|---|---|---|---|
| 1. My child understands simple directions. | | | | |
| 2. My child can identify body parts. | | | | |
| 3. My child recognizes pictures and objects. | | | | |
| 4. My child turns his/her head when his/her name is called. | | | | |
| 5. My child communicates with intent. | | | | |
| 6. My child answers "wh" questions. | | | | |
| 7. My child has hearing loss. | | | | |
| 8. My child hears and/or uses another language other than English at home. | | | | If "*yes*", which language(s)? |

How does your child communicate at home (PECS, augmentative/alternative communication device, American Sign Language, gestures, verbal)?

_____

_____

_____

_____

How many words are in your child's speaking vocabulary? _____under 25 _____ 25-75 _____over 75

How many words can your child understand? _____under 25 _____ 25-75 _____over 75

Please describe any communication difficulties/concerns.

_____
_____
_____
_____

When were problems *(if present)* first observed? _____

## L. Describe your child's educational background below.

| Education | YES | NO | N/A | Comments |
|---|---|---|---|---|
| 1. Does your child attend school/preschool/childcare? | | | | *If "yes",* what school/center does your child attend? |
| 2. Does your child receive special education or therapies in his/her school or center? | | | | *If "yes",* what is the frequency of OT, ST, & PT sessions?<br><br>How long are the sessions?<br><br>Are they group or individual sessions? |
| 3. May we communicate with your child's school or center staff? (If *yes,* please complete the *HIPAA Authorization* on page 5) | | | | |
| 4. Has your child ever repeated a grade? | | | | *If "yes",* which one? |

What grade or age level setting is your child in right now?

_____

What is his/her current teacher's name(s) and phone number?

_____

If applicable, what are his/her therapists' names and phone numbers?

_____

## M. What are your greatest concerns?

1. How concerned are you with your child's fine motor movement (movement with hands, etc.)?

| extremely concerned | very concerned | moderately concerned | mildly concerned | not concerned |
|---|---|---|---|---|
| **5** | **4** | **3** | **2** | **1** |

2. How concerned are you with your child's gross motor movement (full body movement)?

| extremely concerned | very concerned | moderately concerned | mildly concerned | not concerned |
|---|---|---|---|---|
| **5** | **4** | **3** | **2** | **1** |

3. How concerned are you with your child's speech and language development?

| extremely concerned | very concerned | moderately concerned | mildly concerned | not concerned |
|---|---|---|---|---|
| **5** | **4** | **3** | **2** | **1** |

4. How concerned are you with your child's sensory behaviors?

| extremely concerned | very concerned | moderately concerned | mildly concerned | not concerned |
|---|---|---|---|---|
| **5** | **4** | **3** | **2** | **1** |

5. How concerned are you with your child's social behavior?

| extremely concerned | very concerned | moderately concerned | mildly concerned | not concerned |
|---|---|---|---|---|
| **5** | **4** | **3** | **2** | **1** |

6. How concerned are you with your child's mobility?

| extremely concerned | very concerned | moderately concerned | mildly concerned | not concerned |
|---|---|---|---|---|
| **5** | **4** | **3** | **2** | **1** |

7. How concerned are you with your child's feeding?

| extremely concerned | very concerned | moderately concerned | mildly concerned | not concerned |
|---|---|---|---|---|
| **5** | **4** | **3** | **2** | **1** |

8. Are you concerned about your child's progress at school?

| extremely concerned | very concerned | moderately concerned | mildly concerned | not concerned |
|---|---|---|---|---|
| **5** | **4** | **3** | **2** | **1** |

Describe your concerns: