Patient Information:

Child's full name:_____ Date of Birth: _____ Age: _____

Address: _____ City: _____
State:_____ Zip:_____

Language spoken in the home: _____ Race: _____

Gender: _____

Is the patient a foster child? Yes No

Case Worker Name: _____ Agency: _____

Phone: _____ Fax:_____

Additional information regarding care, contact, and restrictions:

_____

_____

Guardian Information:

Guardian's Name (1): _____ _____ Occupation: _____

Address: _____ City: _____
State:_____ Zip: _____

Home Phone: _____ Cell Phone:_____
Work Phone: _____ E-mail:_____

Guardian's Name (2):_____ _____ Occupation: _____

Address:_____ City:_____
State:_____ Zip:_____

Home Phone: _____ Cell Phone:_____
Work Pone:_____ E-mail: _____

Social History:

Referral Source: _____

Reason for Referral: _____

People living in the home:

Name of person	Age	Relation to the child

Birth History:

Age of mother when pregnant _____

Complications during pregnancy (explain):

_____

_____

Weeks gestation at Birth: _____ Did mother receive prenatal care? Yes No

Birth weight: _____ Length at Birth: _____

Uncomplicated labor: Yes No

Complications (check all that apply):

___ difficult delivery _____ breech position

___ Jaundice _____forceps used

___ Cesarean section _____ low APGAR Scores

___ Birth Injury or complications at birth (explain):

_____

_____

_____

Developmental History:

Give the approximate age when your child:

First began to crawl _____ First walked independently _____

Was toilet trained during the day _____ Was toilet trained during the night _____

Began using single words _____ Began using understandable phrases _____

Could feed self independently _____ Put on/took off clothing by self _____

Was your child difficult to care for in infancy? (explain)

_____

_____

Was feeding/eating a problem?(explain)

_____

_____

Was coordination a problem?(explain)

_____

_____

When were you first concerned there could be a problem? _____

Other concerns about your child's development?

_____

_____

Child's strengths:

_____

_____

MEDICAL AND MENTAL HEALTH HISTORY:

Primary Care Physician/Pediatrician (Name and Facility):

_____

Physician Phone Number: _____

Physician Fax Number: _____

List physicians/clinics/specialists involved with child:

Physician	Clinic	Fax Number	Area of Specialty

Has the child ever had problems with or needed (check all that apply):

_____ Glasses/had vision difficulties

_____ Hearing difficulties/hearing devices

_____ Chronic ear infections

_____ Ear tubes

_____ Asthma

_____ Seizures (explain): _____

_____Allergies (explain): _____

_____ Orthopedic braces (explain) _____

Specific Medical Diagnoses: _____ _____

Has your child been hospitalized since birth: Yes No

Hospital	Dates of hospitalization	Reason for hospitalization

List all medications the child takes:

Medications	Purpose	Dosage	Times per day	How long on Medication

Has the child received counseling or had a psychological evaluation at a hospital, mental health center?

Name of Counselor/clinic	Dates	Reason for Treatment

Education Information:

Child's School: _____ Phone Number: _____

Present grade level:_____

Special services received in school: OT PT Speech Other: _____

Does your child receive any of the following?

___Special Education

___Behavior Intervention

___Other special service

Does your child's teacher have concerns with your child's development? If so, please explain:

_____

_____

Insurance Information:

** Please list all insurance plans for which the patient is a beneficiary, even if you know that therapy will not be covered by this plan. Please include any and all commercial insurance policies that list your child as a beneficiary in order to ensure that claims are processed appropriately.

Primary Insurance:

Policy Holder's Name:_____
DOB:_____

Relationship to Patient: _____

Employer: _____

Insurance Company Name & Address:

_____

Phone: _____

Policy ID# :_____ Group #_____

Secondary Insurance (if applicable):

Policy Holder's Name:_____
DOB:_____

Relationship to Patient: _____

Employer: _____

Insurance Company Name & Address:

_____

Phone: _____

Policy ID# :_____ Group #_____

Emergency Care Information/Consent:

Conditions Which May Require Immediate or Emergency Care (i.e., diabetes, epilepsy, bee sting reactions, allergies, etc.)

1. _____ Treatment _____
2. _____Treatment _____

If my child becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or above-named physician to give the emergency medical treatment required:

Hospital _____ Address _____

Caregiver's Name _____ Phone (_____) I give permission for the above named caregiver to pick up my child from Marcfirst Pediatric Therapy Program when my child's therapy is finished.

In the event that another person will pick up my child, I will notify Marcfirst Pediatric Therapy Program

. Parent's Signature _____ Date _____

Please include any information that is checked below:

_____ Copy of Insurance Card (front and back)

_____ Prescription from Physician for the following: _____

_____ Current IEP from child's school

_____ Diagnostic Report

_____ Report from the following medical specialist/therapists: _____

_____ Release/precautions from the following medical specialist: _____