Physical Therapy: Dr. Kristen McDermaid, DPT
Occupational Therapy: Ronel Claassens OTR/L
Speech/Language Therapy: Ericka Shuptar MS, CCC-SLP

Dear new family,

Welcome to Capitol Area Physical Therapy Associates - Pediatrics (CAPTA). We are looking forward to evaluating your son/daughter. We are located at 830 W. Lake Lansing Road, Suite 250, East Lansing, MI (in the Oak Grove Office Park, just west of Harrison Rd and east of Coolidge Rd.)

What to expect during your child's evaluation:

Our physical therapy, speech/language therapy, and occupational therapy evaluations incorporate toys, games, and kid friendly activities. The therapist will discuss your concerns, your goals, and your child's case history (e.g. developmental milestones) during your initial visit. The therapist will observe your child during play and during structured activities that look at specific skills. Based on your child's age, ability, and comfort level, parents may be asked to separate from their child during parts of the evaluation and/or treatment and wait in the waiting room. Often, a standardized test will be administered that will compare your child's skills with the skills of other children that are the same age. At the end of the evaluation (and often during the evaluation), the therapist will discuss the skills and areas of need that she is observing during the evaluation and determine if therapy is warranted. Following the evaluation, your therapist will write a report, formulate goals, and establish a plan of care that will be shared with your child's doctor and parents (if desired).

Please bring the following with you to your child's evaluation

- Registration forms (enclosed)
- Insurance card(s)
- ID/drivers license
- Reports or school paperwork (e.g. IEP, 504 Plan) or related therapy or evaluations
- For speech/language evaluation: toy and/or snack that will help your child feel comfortable during the evaluation

See you soon! Please call if you have any questions.

Thanks,

CAPTA pediatric therapists

830 W. Lake Lansing Road, Suite 250, E. Lansing, MI 48912
Phone: 517.333.8533 Fax: 517.333.8539

Account #:_____

PEDIATRIC REGISTRATION

Date:_____

Patient Name:_____ Sex: M / F DOB:___/___/___
LAST FIRST MI MO DAY YR

Home Phone: (___)_____-_____ Social Security Number:_____-_____-_____

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

Parent/Guardian Name(s):_____

Parent Contact information (phone/e-mail): _____

Are parents: Married Separated Divorced Other_____

Referring Physician:_____ Phone: (___)_____-_____

Primary Care Physician:_____ Phone: (___)_____-_____

Emergency Contact:_____ Phone: (___)_____-_____

Relationship to patient:_____

DATABASE

Chief Complaint/Reason for Referral:_____

_____

Goals for Child:_____

_____

Prenatal History
Previous Pregnancies:_____
Mother's general health/chronic illness:_____
Known genetic/family history:_____

Natal History
Child's Birth Weight:_____ Length of Gestation:_____
Length of Labor:_____ APGAR Score (if known):_____
Birth Order: single twin A twin B twin C
Delivery: vaginal forceps vacuum assist cesarean section breech
Complications during birth:_____

Postnatal History
Length of Hospital Stay:_____
Complications following birth:_____
Infections:_____
Medications:_____

Ventilation Required: Yes No O2 Required: Yes No Amount:_____
Transfusions/Phototherapy: Yes No Types:_____

Account #:_____

Concerns or trouble regarding feeding? Yes No
Insertion of PE/ear tubes? Yes No

Past Medical History

History of: Seizures Asthma Respiratory Infection Ear Infection Reflux
Cardiac Neurological Problems Cancer Thyroid Kidney Stones
Other:_____

Past Surgical/Hospitalization History

List all surgeries or hospitalizations:_____

_____

Medications

List all medications and/or supplements:_____

_____

Allergies

List all known drug, food or environmental allergies:_____

_____

Is child allergic to latex: Yes No

Medical Tests

Has child had: Radiographs MRI CT Scan Swallow Tests Other_____
Results:_____

Medical Evaluations

Previous medical evaluations including neurological, physiological, cardiac or educational:_____

_____

Name of Dr./Therapist:_____
Date of exam:_____
Institute:_____
Outcome:_____
Other Diagnoses:_____

Therapy History

Has child had previous: Physical Therapy Occupational Therapy Speech Therapy
If so, when?_____ Where?_____ For how long?_____
Outcomes:_____

Schooling

Present School:_____ Grade:_____
Is child receiving services in school? Yes No If so, what services?_____
Is there an Individualized Educational Program (IEP) in place? Yes No
If so, do you have a copy? Yes No

Vision/Hearing

List any visual or hearing problems/concerns:_____
Does child wear glasses? Yes No Contacts: Yes No Hearing Devices: Yes No
Does child have ear tubes? Yes No
Other:_____

Current Equipment

For or Ambulation: Walker Crutches Loft-Strand Crutches Wheelchair

Account #:_____

Braces:_____

Other:_____

Who is the vendor(s) for equipment?_____

For Communication: Augmentative Communication Device
Picture-Based Communication System
Use of schedules and/or social stories

Growth & Development

At approximately what age did child perform activities? (Or check all that apply)

Gross Motor Skills:

Lift Chin on Stomach_____	Roll_____
Sit Alone_____	4-point_____
Crawl_____	Pull to Stand_____
Stand Alone_____	Walk Alone_____
Climb Stairs_____	Run_____
Jump_____	Ride Bike_____

Fine Motor Skills:

Reach_____	Grasp_____
Eat with fingers_____	Use Utensils_____
Drink from cup_____	Scribble/Draw_____
Button/Zip_____	Stack Blocks_____
Open/Close Containers_____	Lace Shoes_____
Cut with scissors_____	Use toilet_____

Activities of Daily Living:

To what extent does the child perform the following activities?

	Independent	Mild Assist	Moderate Assist	Complete Assist
Wash/bathe				
Eat				
Toilet				
Dress				
Brush Teeth				

Speech and Language:

Primary language:_____ Other languages spoken in the home_____

Does child have difficulty expressing needs/wants?	Yes	No
Does child have unclear speech?	Yes	No
Does child use and/or understand sign language?	Yes	No
Can child follow simple commands?	Yes	No
Can child follow complex commands?	Yes	No
Is child's vocabulary limited?	Yes	No

If yes, approximately how many words is child using?_____

Did child using pacifiers?_____ Bottles?_____ Thumb Sucking?_____

Behavioral Characteristics

Cooperative	Willing to try new activities	Short attention/easily distracted
Attentive	Poor eye contact	Destructive/aggressive
Stubborn	Separation Difficulties	Easily frustrated/impulsive
Self-Abusive	Withdrawn	Plays alone

Account #:_____

Pain Assessment

Does child appear in or complain of pain? Yes No

If so, where?_____

How does child display signs of discomfort?_____

Can child express his/her own pain or discomfort using the faces below? Please circle.

Consent

I understand that my child's medical information is confidential and can not be released without my authorization. I also understand that I may not always be able to bring my child to his/her therapy sessions. I authorize the following individuals to bring my child for their therapy treatments and give permission to the following individuals to obtain applicable information from CAPTA regarding my child's therapy, both verbal and written and can sign for consent if medically necessary:

Name:_____ Relationship:_____ Phone: (___) ____-____

Name:_____ Relationship:_____ Phone: (___) ____-____

Name:_____ Relationship:_____ Phone: (___) ____-____

Account #:_____

Consent For Treatment

I hereby give consent to Capitol Physical Therapy Associates, Inc. and its designated agents to provide evaluative and treatment services as necessary and reasonable for my child's care.

_____ _____

Signature Date

Authorization to Release Medical Information

I hereby authorize Capitol Physical Therapy Associates, Inc. to release any information necessary to process this claim.

_____ _____

Signature Date

Billing Policy

Capitol Physical Therapy Associates, Inc. as a service to our patients will submit your claim to your insurance company. Capitol Physical Therapy Associates, Inc. participates with most insurance companies *(see below). You are responsible for any copays and/or deductible according to your individual policy. Please check with your insurance company for the details of your policy since ultimately you are the person responsible for the cost of treatment. As payments are received by us from your insurance company, we will bill you for any copays or deductible that may apply. Please make payment as you receive each bill. A billing fee of $4.00 will be added for every duplicate statement sent for unpaid balances. If you know that paying your balance will be a hardship, please contact our billing office to work out payment arrangements. If it becomes evident that no effort is being made towards payment, your bill will be turned over to a collection agency. I have read and UNDERSTAND the above and agree to accept responsibility for any balance on my account that is not payable by my insurance company. I give Capitol Physical Therapy Associates, Inc. permission to bill my insurance company on my behalf.

_____ _____

Signature Date

*Not all insurance companies are willing to pay for rehabilitation services at Capitol Physical Therapy Associates, Inc. Again, please check with your insurance company regarding any stipulations.

Acknowledgement of Notice of Privacy Practices

I have received and read the Notice of Privacy Practices of Capitol Physical Therapy Associates, Inc. You may request a copy.

_____ _____

Signature Date