



*Speech/Language Therapy
Occupational Therapy
Physical Therapy*

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)
- Prescription for evaluation and treatment (or have Doctor's office fax)
- 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
www.captapediatrics.com



Account #: _____

PEDIATRIC REGISTRATION

Date: _____

Patient Name: _____ DOB: ____/____/____ Age: _____
LAST FIRST MI MO DAY YR

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

Contact Phone: (____) _____ - _____ Social Security Number: _____ - _____

Parent/Guardian Name(s) and Phone #'s: _____

Are parents: Married Separated Divorced Other _____

E-Mail Address: _____

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

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

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

Relationship to patient: _____

Other individuals authorized to bring child to therapy (please list names and contact info)

**PLEASE LIST AGAIN ON SIGNED CONSENT FORM*

DATABASE

Chief Complaint/Reason for Referral: _____

Goals for Child (Physical Therapy - Gross Motor): _____

Goals for Child (Occupational Therapy - Fine Motor/Activities of Daily Living): _____

Goals for Child (Speech/Language Therapy) _____

Favorite Toys/Activities: _____

Family History

Sibling Name	Age	Sex

Other individuals living in the home: _____

Parent/Guardian Occupation(s): _____

Account #: _____

Have any family members had any speech, language, hearing problems, behavioral, mental health or learning difficulties? No Yes

Please describe: _____

What languages are spoken in the home? _____

What is the primary language used with this child? _____

Is/was this child adopted (or in foster care)? No Yes

If Yes, at what age? _____ From Where? _____

Pregnancy/Prenatal History

Age of Mother (during pregnancy): _____

Mother's general health: _____

Pregnancy Complications: _____

Natal History

Child's Birth Weight: _____

Length of Pregnancy (full term/preterm) _____

Birth Order: single twin A twin B

Delivery: vaginal forceps vacuum assist cesarean section breech

Complications during birth: _____

Postnatal History

Intensive Care (NICU) needed : yes no Length of stay: _____

Any health problems or medications the first 2 weeks of life? _____

Ventilation Required: Yes No Oxygen Required: Yes No Amount: _____

Transfusions/Phototherapy: Yes No Types: _____

Concerns or trouble regarding feeding (in infancy)? Yes No

Past Medical History

History of: Seizures Asthma Respiratory Infection Ear Infection Reflux
 Cardiac Neurological Problems Cancer Thyroid Kidney Stones
 Picky eating Sensory concerns

Other: _____

Past Surgical/Hospitalization History (e.g., PE tubes, tonsils/adenoids removed)

List all surgeries or hospitalizations (list dates): _____

Medications

List all medications and/or supplements: _____

Allergies

List all known drug allergies, food allergies/restrictions, environmental allergies: _____

Is child allergic to latex: Yes No

Medical Tests (list dates of tests)

Has child had: X-rays MRI CT Scan Swallow Tests Other _____

Results: _____

Evaluations

Previous 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
 ABA/behavioral therapy Other: _____

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

Does child have ear tubes? Yes No Hearing Devices: Yes No

Has hearing and vision been tested recently? Yes No When? Results? _____

Current Equipment

Who is the vendor(s) for equipment? _____

- Walker Crutches Loft-Strand Crutches Wheelchair Braces: _____
- Communication Device: _____ Other: _____

Growth & Development

Gross Motor Skills: At what age did child perform activities? (Or indicate typical/delayed)

- | | |
|--|--|
| <input type="checkbox"/> Roll _____ | <input type="checkbox"/> Jump/hop _____ |
| <input type="checkbox"/> Sit Alone _____ | <input type="checkbox"/> Climb Stairs _____ |
| <input type="checkbox"/> Crawl _____ | <input type="checkbox"/> Walk backward _____ |
| <input type="checkbox"/> Run _____ | <input type="checkbox"/> Ride Bike _____ |
| <input type="checkbox"/> Stand Alone _____ | <input type="checkbox"/> Skip/Gallop _____ |
| <input type="checkbox"/> Walk Alone _____ | |

Fine Motor Skills: At what age did child perform activities? (Or indicate typical/delayed)

- | | |
|---|--|
| <input type="checkbox"/> Eat with fingers _____ | <input type="checkbox"/> Use Utensils _____ |
| <input type="checkbox"/> Drink from cup _____ | <input type="checkbox"/> Scribble/Draw _____ |
| <input type="checkbox"/> Use a straw _____ | <input type="checkbox"/> Cut with scissors _____ |
| <input type="checkbox"/> Stack Blocks _____ | <input type="checkbox"/> Use toilet _____ |

Dominant Hand Preference: RIGHT LEFT BOTH

Check if appropriate: Trips often Clumsy Afraid of heights/climbing

Avoids uneven surfaces

Activities of Daily Living:

To what extent does the child perform the following activities?

	Independent	Mild Assist	Moderate Assist	Complete Assist
Wash/bathe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dress/undress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Button/zip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tie shoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brush Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Feeding:

Does your child have difficulty sucking, swallowing, chewing, or eating different textures?

- Yes No Describe: _____
- Strong food preferences
- Avoids/dislikes certain foods

Speech and Language:

At what age did the child perform activities? (or indicate typical/delayed)

Activity	Age
Babbling (e.g., "ba, ba")	
Use first words	
Put 2-3 words together	
Put sentences together	
Engage in conversation	

- Does child have difficulty expressing needs/wants? Yes No
- Is your child's voice hoarse or husky? Yes No
- Can child follow simple commands? Yes No
- Can child follow complex commands? Yes No
- Does child have difficulty answering questions? Yes No
- Is child's vocabulary limited? Yes No

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

Does your child stutter? Yes No Describe: _____

How does your child usually communicate (check all that apply)?

- Gestures Crying Leading Single words Short phrases Sentences

Approximately how much of your child's speech do you understand?

- Less than 10% 25% 50% 75% 90% - 100%

Approximately how much of your child's speech do those less familiar with the child understand?

- Less than 10% 25% 50% 75% 90% - 100%

Please indicate when/if the child stopped:

Activity	Age stopped
Using pacifiers?	
Using bottles?	
Thumb Sucking?	
Nursing?	

Social/Play/Academic Skills:

How does your child play with other children (cooperative, leader, lone, aggressive, passive, etc):

Does your child engage in conversation or verbally interact with peers? _____

Does your child make friends easily? Yes No

Does your child need to be in control? Yes No

List any concerns you may have about your child's social/play skills:

Any academic or learning concerns? Yes No Describe: _____

Behavioral Characteristics

No Specific Problems Short Attention Span Self

Injurious Behavior

Easily Frustrated Plays Well With Others Easily Distracted

Difficult to Discipline Cooperative Willing to try new activities

Poor eye contact Destructive/aggressive

Stubborn Separation Difficulties

Does your child express frustration related to communication or motor issues? _____

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 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 for Insurance

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

Signature Date

Authorization to Release Medical Information to Family/Non-Family Members

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: () - _____

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



This policy has been established to help us serve you and your child better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late-cancellations delay the delivery of health care to other patients.

A “no-show” is missing a scheduled appointment. A “late-cancellation” is canceling an appointment without calling us within 24 hours in advance of an office visit.

We understand that situations such as medical emergencies and sickness occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis. However, if your child is too ill to participate in treatment or may be contagious, please cancel your appointment. If you or your child arrives ill, you will be dismissed and charged a fee of **\$25.00** for the session.

Because this office holds a time for your session, you are essentially promising to fulfill that slot. Consistent attendance is essential in order for your child to make progress in treatment sessions. If you exceed a cancellation rate of 25 percent or higher you will receive a written notice that your slot is in jeopardy, especially if you do not attempt to schedule or attend make-up sessions. This policy includes emergency, non-emergency and vacation cancellations.

A charge of **\$25.00** will be assessed for each no show or late cancellation office visit appointment if less than 24 hours notice is given.

Please understand that insurance companies consider this charge to be entirely the patient’s responsibility.

Signature

Date