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:_____

Account #:_____

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)

☐ Roll_____ ☐ Jump/hop_____
☐ Sit Alone_____ ☐ Climb Stairs_____
☐ Crawl_____ ☐ Walk backward_____
☐ Run_____ ☐ Ride Bike_____
☐ Stand Alone_____ ☐ Skip/Gallop_____
☐ Walk Alone_____

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

□ Eat with fingers_____ □ Use Utensils_____
□ Drink from cup_____ □ Scribble/Draw_____
☐ Use a straw_____ ☐ Cut with scissors_____
□ Stack Blocks_____ ☐ 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	☐	☐	☐	☐
Eat	☐	☐	☐	☐
Toilet	☐	☐	☐	☐
Dress/undress	☐	☐	☐	☐
Button/zip	☐	☐	☐	☐
Tie shoes	☐	☐	☐	☐
Brush Teeth	☐	☐	☐	☐

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?	

Account #:_____

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.

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 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

Account #:_____

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