Account #: _____

PEDIATRIC THERAPY 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:

Name: _____ Phone: (____) ____-_____ ☐ Parent ☐ Guardian

Name: _____ Phone: (____) ____-_____ ☐ Parent ☐ Guardian

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 the child to therapy (please list names and contact info)

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

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

**PLEASE LIST AUTHORIZED INDIVIDUALS AGAIN ON SIGNED CONSENT FORM*

Have you been seen at a CAPTA Pediatric clinic before? Yes ☐ No ☐

How did you hear about CAPTA Pediatrics?

Returning Patient ☐ Family/Friend ☐ Web-Site ☐ Newspaper Ad ☐

Physician Recommend ☐ Facebook ☐ TV Ad ☐ Mailing ☐

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:

Account #: _____

Sibling Name	Age	Gender

Other individuals living in the home:

_____

Parent/Guardian

Occupation(s): _____

Have any family members had any speech, language, hearing problems, behavioral, mental health or learning difficulties?

☐ No ☐ Yes 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)? ☐ Yes ☐ No

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: ___ lbs ___ ozs

Length of Pregnancy (full term/preterm): _____

Birth Order: ☐ single ☐ twin A ☐ twin B

Delivery: ☐ vaginal ☐ forceps ☐ vacuum assist ☐ caesarean 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: _____

Concern or trouble regarding feeding (in infancy)? ☐ Yes ☐ No

Past Medical History

History of:

☐ Seizures	☐ Asthma	☐ Thyroid	☐ Respiratory infection
☐ Cardiac	☐ Reflux	☐ Ear Infection	☐ Sensory Concerns
☐ Picky eating	☐ Cancer	☐ Kidney Stones	☐ Neurological Problems

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): Account #: _____

_____

_____

Allergies (List all drug allergies, food allergies/restrictions, environmental allergies):

_____

_____

Is the 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 service? _____

Is there an Individualized Educational Program (IEP) in place? ☐ 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 (Type) _____

☐ Communication Device (Type) _____ 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	_____

Account #: _____

Dominant Hand Preference: ☐ Left ☐ Right ☐ 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 the 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 your child have difficulty expressing needs/wants? ☐ Yes ☐ No

Is the child's voice hoarse or husky? ☐ Yes ☐ No

Can the child follow simple commands? ☐ Yes ☐ No

Can the child follow complex commands? ☐ Yes ☐ No

Does the child have difficulty answering questions? ☐ Yes ☐ No

Is the child's vocabulary limited? ☐ Yes ☐ No

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

Does the child stutter? ☐ Yes ☐ No Describe: _____

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

☐ Gestures ☐ Crying ☐ Leading ☐ Single words ☐ Short phrases ☐ Sentences

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

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

Approximately how much of the 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/Acedemic Skills:
How does the child play with other children (cooperative, leader, lone, aggressive, passive, etc):

_____

Does the child engage in conversation or verbally interact with peers? ☐ Yes ☐ No

Does the child make friends easily? ☐ Yes ☐ No

Does the child need to be in control? ☐ Yes ☐ No

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

_____

Any academic or learning concerns? ☐ Yes ☐ No

Describe: _____

Behavioral Characteristics

☐ No Specific Problems	☐ Stubborn	☐ Destructive/aggressive
☐ Easily Frustrated	☐ Short Attention Span	☐ Separation Difficulties
☐ Difficult to Discipline	☐ Plays Well with Others	☐ Easily Distracted
☐ Poor eye contact	☐ Cooperative	☐ Willing to try new activities

Does your child express frustration related to communication or motor skills? ☐ Yes ☐ No

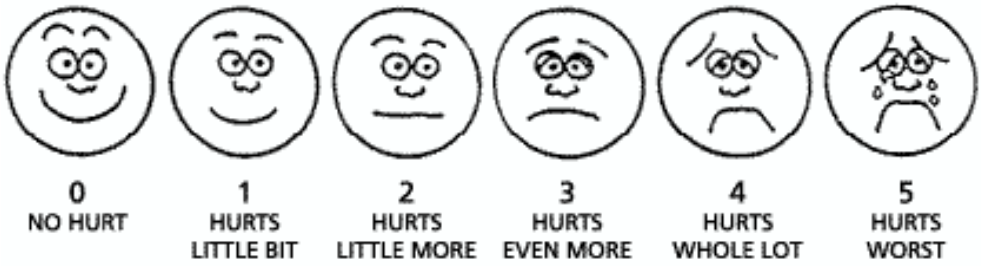
Pain Assessment

Does the child appear in or complain of pain? ☐ Yes ☐ No

If so, where? _____

How does the child display signs of discomfort? _____

Can the child express his/her own pain or discomfort using the faces below? Mark one



0 1 2 3 4 5

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 the 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 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 the 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 the 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