Professional Therapy Services, Inc.

1015 Oakhurst Drive
Charleston, WV 25314
www.wvpts.com
304-345-8101 / fax: 304-345-7386

"Playing To Succeed!"

Name:_____ Birth Date:_____

Age:_____ Sex:_____ SSN of Insured Party:_____

Address:_____

City:_____ State:_____ Zip:_____

In Case of Emergency, please contact:_____Relationship:_____

work:_____home:_____cell:_____

Mother/Guardian Name:_____ Birth Date:_____

Phone Number - work:_____home:_____cell:_____

Father/Guardian Name:_____ Birth Date:_____

Phone Number - work:_____home:_____cell:_____

Name of Additional Caregivers: _____

Phone Number - work:_____home:_____cell:_____

Who referred you for assessment? And why?_____

_____

Child's Current Pediatrician:_____

I. Medical History:

A. Prenatal & Birth

1. General health during pregnancy (illnesses, accidents or infections?) & length of pregnancy: _____
2. Birth Weight:_____ Delivery: ☐Normal ☐ Breech ☐Caesarian
3. Were there any complications, such as:
   ☐ Difficulty breathing ☐ Congenital defects ☐ Blue color at birth _____
   ☐ Limpness ☐ Jaundice ☐ Other:_____
4. Was there a need for:
   ☐ Oxygen ☐Transfusions ☐Respirator ☐Tube feedings
5. Were there any feeding difficulties? (If so, please describe)_____
6. Did the child have problems sucking, swallowing or breathing?_____
7. Was the child's length of stay in the hospital unusually long? (If so, please describe)_____
   _____

B. Illnesses (Please check all that apply; If applicable, please give date):

☐ Colds ☐ CMV ☐ RSV ☐ Asthma ☐ Seizures/Convulsions
☐ Ear Infections ☐ Parent's history of drug/alcohol abuse ☐Other:_____
☐ Hepatitis ☐ MRSA ☐AIDS/HIV ☐ Diabetes ☐ Heart Trouble

Allergies (If so, please specify) _____

Injuries or Surgeries (if so, please explain) _____

1. Are immunizations up to date? ☐Yes ☐No (if no, please explain)_____
2. Please list date of child's last physical examination: _____Doctor:_____
3. Has your child had a hearing evaluation? ☐Yes ☐No Results: _____
   By whom:_____Date:_____
4. Has your child had an eye evaluation? ☐Yes ☐No Results: _____
   By whom:_____Date:_____
5. Has your child ever required hospitalization or surgery? (If so, please describe nature and date)
   _____
6. Please describe any serious injuries or accidents: _____
   _____
7. Is your child currently on any medications? (Please list & state reason, if applicable):_____
   _____
8. Past/Present services used to address problem areas:_____
   _____

II. Developmental History:

A. Please give approximate age when child first:

Rolled over(stomach to back)____ (back to stomach)____ Sat without support____

Crawled____ Walked alone____ Toilet Trained_____ Said first word _____

Sucked thumb (how long did he/she suck thumb?)____

Used pacifier (how long was it used?)____

B. Does your child have any of the following: (Please check all that apply)

☐ Sleeping problems ☐ Feeding problems ☐ Tires more easily than peers

☐ Difficulty drawing ☐ Difficulty picking up & holding objects readily

☐Difficulty grasping objects ☐Difficulty dressing ☐ Appear awkward/uncoordinated

☐ Sensitivities to being touched ☐ Sensitivities to clothing textures

☐ Difficulties keeping hands to self ☐ Difficulty choosing hand dominance(age 5 & older)

☐ Difficulty learning new activities involving large movements of the body

☐ Tend to avoid large movements during play (ex. Rough & tumble play)

☐ Difficulty changing activities ☐ Difficulty attending to activities ☐ Fall/lose balance easily

III. General Behavior

A. Please check all characteristics that apply to your child:

☐ Friendly ☐ Shy ☐ Hyperactive ☐Angry ☐Nervous ☐Stubborn

☐ Sucks Thumb ☐ Plays Alone ☐ Wets bed ☐ Throws Tantrums

☐ Plays primarily with Older/Younger Children

1. How does he/she get along with other children? _____ Adults? _____
2. Does your child prefer to play alone or with others?_____
3. Do you think your child is able to participate with a structured, standardized assessment lasting:

☐15 minutes ☐30 minutes ☐60 minutes ☐not able to participate

4. Do you have concerns about your child's behavior? Please describe. _____

_____

5. Is your child ever aggressive with others? If so, please explain. _____

_____

IV. Educational/Family Background:

1. Please list any day care centers/schools that your child has attended.

(Please include Grade Level, City & State):_____

_____

2. Does he/she have any specific problems in school or receive any at school services? _____

_____

3. Has anyone on either side of the family had speech, learning or motor problems? (If so, please list relationship to child & problem)_____

_____

V. Comments:

If there are any factors that you feel would help in evaluating your child that are not covered in this form, please describe below. Use a separate sheet if necessary. Thank you.

_____

_____

_____

_____

_____

_____

_____

Parent Signature: _____

Relationship to Child:_____

Date Completed: _____

For Speech Therapy Evaluation – Skip to Section VI

For Occupational Therapy Evaluation – Skip to Section VII

For Physical Therapy Evaluation – Skip to Section VIII

VI. Speech/Language Therapy:

A. Early

1. At what age did he/she "coo" or babble? _____
2. At what age did he/she use words meaningfully? Name people & objects? _____
3. At what age did your child combine words into small sentences? Ex. "Want drink" or "Me out" _____
4. At what age did your child use more complete sentences? Ex. "I want a drink" or "Let me go out" _____

B. Speech Intelligibility:

☐ Easily understood by all ☐ Understood by family

☐ Not completely understood ☐ Other _____

☐ Communicates through gestures only

C. Does your child:

1. Express him/herself as well as others his/her age? _____
2. Understand as well as others his/her age? _____
3. Remember what is said to him/her as well as others his/her age? _____
4. Follow instructions as well as others his/her age? _____
5. Describe your child's early reactions to sound: _____
6. Was his/her early speech easy to understand? _____
7. Have difficulty swallowing/eating particular foods or eating a variety of foods? _____
8. Stutter or repeat sounds, words or phrases? _____
9. Become "hoarse" or have other voice problems? _____
10. Use his/her speech seldom, frequently or never? _____
11. Problem seem worse at certain times than others? Please explain: _____
12. Seem aware of the problem? _____
13. Understand/hear a second language at home? If so, what language? _____

_____

VII. Motor & Sensory – Occupational Therapy:

Occupational therapy is therapy based on engagement in meaningful activities of daily life. The primary goals of childhood are to grow, learn and play. For children and youth, occupations are activities that enable them to learn and develop life skills (ex. school activities), be creative (ex. play) and thrive (ex. self-care & care for others).

Occupational therapists address the areas of fine motor skills, self-help skills, sensory integration and attention/regulation to support children in becoming as independent as possible at home, school and in the community.

1. What are your primary concerns regarding your child? _____

   _____

2. What community activities does your child participate in? _____

   _____

3. Name of physicians/specialists following the child?_____

   _____

4. Diagnosis, dates of diagnosis and diagnosing physician if applicable:_____

   _____

A. Sensory (if applicable):
   1. Are you familiar with sensory integration? If so, please explain._____

      _____

   2. What are you hoping to gain from a sensory integration evaluation?_____

      _____

B. Fine Motor Skills/Handwriting:
   1. Do you have any concerns regarding your child's ability to manipulate small objects? Please explain._____

   2. Do you have any concerns regarding your child's handwriting? Please explain._____

      _____

***If Handwriting is a concern, please bring a sample of your child's independent work.**

3. Does your child:
   ☐ snip with scissors ☐ cut straight lines ☐cut curved lines ☐cut simple shapes

C. Self-Help Skills

1. Can your child perform the following skills independently? (Please check all that apply)

   ☐ snap ☐button ☐ zip ☐ dress independently without fasteners

   ☐ toileting ☐ bathing ☐ brush teeth ☐ brush/comb hair

   ☐ manage spoon ☐ manage fork ☐ manage knife ☐ tie shoes

   ☐ drink from cup(s), type(s): _____

   ☐ If your child has any feeding challenges, please describe: _____

   _____

   ☐ Special diet: _____

   ☐ Food allergies: _____

   ☐ Preferred foods: _____

   ☐ Food aversions: _____

2. Please list areas that you would like to see your child gain more independence: _____

   _____

3. Is there any additional information/concerns that will be beneficial to the Occupational Therapy evaluation? _____

   _____

VIII. Physical Therapy

Physical therapy services are designed to reduce pain and improve or restore mobility, in many cases without expensive surgery and often reducing the need for long-term use of prescription medications and their side effects.

Physical therapy helps individuals needing to restore or improve activities necessary of daily life due to illness, injury, disease, disorder, condition, impairment disability, activity limitation or participation restriction.

1. Height & Weight of Child:_____
2. As a parent, what are your primary concerns?_____
3. Has your child ever had Physical Therapy? If so, for what reasons & how was your/their experience? ____

_____

4. How long of a therapy session could your child tolerate? ☐ 30 min ☐ 45 min ☐ 1 hour
5. Are there any fears that your child experiences that the therapist should avoid during functional play?
   ☐ No ☐ Yes – please explain: _____
6. Does your child:
   - ☐ Complain of pain? *If yes, please refer to Chart A*
   - ☐ Complain of pain at night that wakes them up?
   - ☐ Complain of dizziness, vertigo or the room spinning after a positional change?
   - ☐ Fall frequently? If so, please explain:_____
   - ☐ Bruise easily?
   - ☐ Bleed profusely when a scrape/cut occurs?
   - ☐ Walk in the following manner (please circle all that apply):

Tip toe. ☐ Toes in. ☐ Toes out. ☐ Flat/heavy footed. ☐ In a clumsy manner. ☐ Does not walk at all. ☐

7. Is your child:
   - ☐ Able to pay attention to their environment, avoiding hazards 75% of the time?
   - ☐ Able to stand on 1 foot for more than 10 seconds?
   - ☐ Able to jump? If so, how high/far: _____
   - ☐ Able to walk up stairs without using a handrail? If no, please explain how they traverse stairs:

     _____
   - ☐ Able to throw a ball 10 feet both underhanded and overhanded?
   - ☐ Able to catch a ball without closing their eyes and turning their head?
8. Please list any hospitalizations, broken bones, torn ligaments, sprains, strains or other medical emergencies. _____

Stuttering Questionnaire

1. At what age did you first notice stuttering?_____
2. Describe type of stuttering; e.g. Repeat sounds, syllables or get stuck on beginning of words._____

   _____

   _____
3. Have you received Speech Evaluation or Therapy for stuttering? If so, for how long?_____
4. Did your stuttering resolve and then return?_____
5. Has your stuttering worsened? If so, when did you notice change?_____
6. What (if any) works to help you be fluent?_____
7. What circumstances/environment do you notice your speech worsen?_____

   _____

   _____
8. Are there any family members or distant relatives who have or had stuttering difficulties?_____

   _____
9. What are your goals for improving your speech, if any?_____

   _____

   _____

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PATIENT CONSENT FORM

As part of your health care, it is necessary to create, maintain and (in certain situations) share medical information concerning your health history and current health care services to carry out treatment, payment and health care operations. Our **Notice of Privacy Practices** describes how we may use and disclose your protected health information. You have the right to review our notice before signing this consent.

The terms of our notice may change. We will post a copy of the current notice in our facility. At any time you may request a copy of our current notice in effect.

You have the right to request that we restrict how protected health information about you is used or disclosed for health care treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by those restrictions to which we agree.

By signing this form, you consent to our use and disclosure of protected health information about you for health care treatment, payment and health care operations and you acknowledge that you have received a paper copy of our **Notice of Privacy Practices**. You have the right to revoke this consent, in writing, except where we have already used or disclosed your information in reliance on your prior consent.

_____ _____

Patient/Personal Representative Date

_____ _____

Patient Name Date of Birth

Professional Therapy Services, Inc,
1015 Oakhurst Drive, Charleston, WV. 25314
Telephone: (304)345-8101 FAX: (304)345-7386

Thank you for choosing Professional Therapy Services, Inc. as your provider of therapy services. We offer Speech and Language, Occupational, Physical and Music Therapy. Our goal is to provide you and your family with the most current and effective treatment possible.

Financial Policy

The following information is provided to avoid any misunderstanding or disagreement concerning your responsibilities and payment for the professional services provided to you. Prompt payment allows us to control cost. Outstanding accounts cost both of us time and money; therefore, all patients will be required to establish financial arrangements for payment of their account. Any and all co-payments, deductibles and coinsurance amounts are due and payable at the time of service. Any services which are deemed "non-covered" or "not medically necessary" by your insurance company or other payor source are your responsibility. If you do not have insurance coverage, you are required to pay at the time of service (Time of Service Discount) unless prior arrangements have been made with our billing department.

Please remember that your insurance coverage is an agreement between you and your insurer. It is your responsibility to communicate with your insurance regarding past due claims that are unpaid. If a problem occurs with your claim, you are required to establish written financial arrangements with Professional Therapy Services, Inc., until your insurance problem is resolved. We will also contact insurance on your behalf; however, you are responsible to resolve any dispute regarding unpaid claims.

You will receive a monthly statement showing current dates of service and any balance due by you. We ask that payment be made within 10 days of your statement date unless prior arrangements have been established.

Neglecting to remit payment after 61 dates of balance due or financial arrangement will force us to limit future credit until the past due balance is settled. All patients will be required to sign a written legal agreement with our practice to alleviate any current delinquency. Please notify us immediately if you feel an error has occurred on your statement. Professional Therapy Services, Inc. firmly believes that the provider/patient relationship is based upon understanding and open communication. We have instructed our staff to make every effort available to clarify any misunderstanding or concern you may have regarding your balance. As a courtesy, our office files claims to your primary insurance, as well as secondary in most cases, on your behalf. We will also provide you with any information you need to submit for additional reimbursement.

Insurance AND Waiver Clients

If is every client or responsible party's obligation to inform Professional Therapy Services, Inc, of any change of insurer or Agency immediately upon transfer. If PTS is not informed in a timely manner, charge for services during the delinquent period will become your responsibility since retroactive billing is often not an option, particularly when prior authorization for services is required.

Attendance Policy

Appointments can be made in person or by calling the office. There is no charge for appointments cancelled 24 hours in advance. AFTER 3 NO SHOWS, OR 3 CANCELLATIONS WITHOUT RESCHEDULING IN A 2 MONTH PERIOD YOU WILL BE REMOVED FROM THE SCHEDULE. Over a three month period, if you attendance is less than 50%, you will be removed from the schedule. Your child does not receive benefit from therapy if your attendance is not regular.

Weather, School Ciosings and Illness

When Kanawha County Schools are delayed or closed due to weather, our office will open at 10 for regularly scheduled clients. Anything prior to that hour will be rescheduled for later in the day, or cancelled. If your child is sick, please do not bring them to therapy. This includes fevers, colds with drainage or cough, flu, or gastrointestinal illness. Particularly during the COVID-19 pandemic, do not attend if you have had contact with anyone who is ill.

Parking

Parking is limited at PTS, so please park carefully allowing as much space for others as possible. If you have difficulty, call the office for assistance. Your therapist can come out to meet your child as needed. Also, if you need to block cars parked on the left side facing the building you can do since, since often that is staff; however, if you are in the therapy session with your child, please let the front office know where you parked in the event you need to move to allow someone out.

PLEASE RETAIN THIS INFORMATION FOR FUTURE REFERENCE