WELCOME TO OUR PRACTICE

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

PATIENT INFORMATION

Name: _____Social Security #: _____Date of Birth: _____

Address: _____

City/State/Zip: _____

Home phone #: _____ Cell phone#:_____

Sex (circle one): Male Female E-mail Address: _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____

Phone: _____

PRIMARY INSURANCE

Person Responsible for Account: _____

Relationship to Patient: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____ Home phone: _____

Copay Amount: _____ Co-Insurance: _____

Visit Type: Occupational Therapy: _____ Speech Therapy: _____ Physical Therapy: _____

Insurance company: _____

Insurance company address: _____

Subscriber I.D. #: _____Group #_____

Authorization Required? Yes/No: _____ Referral Required? Yes/No: _____

ADDITIONAL INSURANCE (if applicable)

Insured name: _____

Relationship to Patient: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Insured Employed by: _____ Business phone: _____

Insurance company: _____

Insurance company address: _____

Subscriber I.D. #: _____Group #:_____

REASON FOR VISIT

Please list your present health concerns, problems or diagnosis: _____

_____

_____

_____

_____

SCHOOL AND THERAPY SERVICES

School/program currently attending: _____ Present grade: _____

Special services received in school: _____ OT _____ PT _____ Speech Therapy _____ Resource services

Special education _____ Behavior intervention _____Other special services _____

Does your child's teacher have concerns about your child's development in any of these areas:

_____ Motor skills _____ Social abilities _____ Self-help skills _____ Cognitive skills/learning abilities

Additional Comments: _____

Do have an IEP from school? Yes ___ No ___ What does it cover? _____

_____

RELEVANT MEDICAL INFORMATION

1. Physicians currently involved in your child's care: _____Phone #:_____
2. Current diagnoses/infections (please list): _____
3. Recent hospitalizations: _____ No _____ Yes If yes, please describe: _____
4. Recent surgery: _____ No _____ Yes If yes, please describe: _____
5. Diagnostic tests: _____ Bone scan _____ MRI _____ CAT scan _____ Upper GI _____ Swallow study _____ X-rays

Results: _____

6. Medications your child currently takes: _____
7. Special equipment your child uses: ____Splint ____Braces ____Walker ____Crutches ____Wheelchair ____ Other
8. Previous psychological testing: _____ No _____ Yes Results of testing indicate (check all that apply):

_____ Learning Disability _____ Attention Deficit Disorder _____ Hyperactivity _____ Intellectual Disability

_____ Developmental Delay _____ Autism/Pervasive Developmental Disorder _____ Behavioral Disturbance

_____ Depression _____ Needs Special Education Services _____ Other

9. Please check all that apply to your child (previous or current):

_____ Seizures _____ G-Tube _____ Food allergies _____ Wears hearing aids _____ Wears glasses

_____ Latex sensitivity _____ Hearing difficulty _____ Vision problem _____ Ear infections