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Patient Information Form

303-649-9007
6535 S. Dayton Street
Suite 3800
Greenwood Village, CO 80111
Fax: 303-649-9008
www.pediatrictherapyinstitute.com

Date: _____

In preparation for your child's first appointment, please fill out this form as fully and accurately as possible as this information will help give us a better understanding of your child. All information is for the confidential use of our staff only.

Child's Full Name_____
First Middle Initial Last Name

Nickname _____

Date of Birth_____ Age Now _____years _____ months

Address: _____ Telephone: _____
Home Cell Work

City: _____ State: _____ Zip: _____ Email: _____

Parents Name: _____ Grade: _____ School: _____

Referred by: _____ Child's Physician: _____

Physician's Address: _____ Telephone: _____

Please describe your concerns about your child's problem in your own words. Chief complaint: _____
_____
_____

When was difficulty first noticed? _____ What has been done about it? _____

Are we billing Insurance on your behalf? _____ Insured's Name: _____

Name of Insurance Company: _____ Member/Provider Services Number: _____
(Please give insurance card to therapist to make photocopy)

Insured's Policy#: _____ Insured's SS#: _____Insured's Date of Birth: _____

Party responsible for payment of services: _____ Telephone: _____

I understand that payment is due at time of session unless other arrangements are agreed upon. I hereby acknowledge and agree that any account that becomes delinquent will be subject to collection service. I agree to pay all court costs and reasonable attorney fees for collection of all past due amounts owed, plus interest thereon at 18% per annum on all amounts outstanding.

_____ _____
Signature Date

Birth History

1. Is this your natural, adopted or stepchild: _____
2. Full term pregnancy? _____ Normal pregnancy in every respect? _____
   If not, describe: _____
3. Length of labor: _____ Natural or Induced: _____ Anesthesia Used? _____
4. Type of delivery: _____ Were instruments used? _____
   Vaginal or Caesarean
5. Normal birth in every respect: _____ Explain if not: _____

6. Any complications of any type before, during or immediately after delivery?
   (Baby placed in incubator, transfused, breathing problems, etc.)
   _____
7. Birth Weight and Height: _____
8. Is child currently small, large or average size for age? _____
9. Did child have any feeding problems: _____

Sensory History

1. As an infant, was the child cuddly? _____ Preferred to be left alone? _____
2. Did the child seem: overly irritable? _____ Average? _____ Overly docile? _____
3. Any unusual sleeping problems or habits during early life? _____ Explain: _____
   _____
4. Tolerate clothing textures? _____
5. Current feeding issues? _____
   (Ex. Texture, taste, temperature)

Motor Milestones

1. At what age did child: Sit alone? _____ Crawl? _____ Pull to stand? _____
   Walk unassisted? _____ Have bladder control? _____ day _____night
   Have bowel control? _____ day _____night
2. Which hand does child use for writing? L or R Eating? L or R Throwing? L or R
3. Has child always used this hand? _____ Was any guidance given? _____
4. Does child seem clumsy with his hands? _____
5. Can child: Cut with scissors? _____ Clap? _____ Scribble: _____Hold pencil correctly? _____
   Print? _____ Write in Cursive: _____ Draw? _____ Draw simple shapes? _____ Draw a man? _____
6. Is child able to dress himself? _____ If not, what does child need assistance with? _____

   _____
   (buttons, snaps, zippers, shoelaces, front and back, entire task)

7. Does child fall or lose balance easily or seem awkward or uncoordinated? _____
8. Does child: Ride a tricycle _____ bicycle _____ catch a ball _____ play ball games _____
   pail/shovel play _____ hide and seek _____other group games _____ Favorite play activity: _____

Hearing/Speech/Language History

1. Other languages spoken in the home: _____
2. Has your child's hearing ever been tested? If so, when, by whom, and what were the results?

3. Has child ever had ear infections? _____ How often? _____ When? _____
4. Has child ever had tubes? _____ When? _____
5. At what age did child begin to: say first words? _____use short phrases? _____
   use complete sentences? _____
6. Has child ever had any type of speech difficulty with sounds or sentences? _____
7. Estimate the number of words the child can say with meaning (not repeating): _____
8. Does child have difficulty: Chewing? _____ Swallowing? _____Excessive drooling? _____
9. How does child communicate his needs: _____
   (words, gestures, etc.)
10. How does the child tell about experiences? _____

Vision History

1. Have your child's eyes ever turned in or out? _____ If yes, age: _____ Describe: _____
2. Does child have visual problem now? _____ Explain: _____
3. When was last eye examination? _____ Doctor's Name: _____
4. What were results and recommendations? _____
5. Describe vision problems of other family members: _____

Medical History

1. Is child healthy and well-rested for today's session? _____ If not, explain: _____
2. What was child's most recent illness: _____ Date: _____
3. Is child currently on medication? _____ Type: _____
4. Does child routinely take any over the counter medications? _____ Type: _____ For: _____
5. Has child had any of the following:

	Date/Age		Date/Age
Frequent Colds	_____	Behavior Problems	_____
Tonsillitis	_____	Car Sickness	_____
Meningitis	_____	Encephalitis	_____
PE Tubes	_____	Allergies	_____
Ear Infections	_____	Head Injuries	_____
Poor Attention	_____	Dehydration	_____
Hyperactivity	_____	Unconsciousness	_____
Seizures/Convulsions	_____	Other	_____

6. Please describe the severity and treatment of items checked above: _____

7. Did the child have extremely high fevers accompanying any of these problems? Explain: _____

8. If child has allergies, which ones and how are they treated? _____

9. Has child ever been hospitalized? When and why? _____

10. Has child ever worn any type of braces, bars or corrective shoes? _____

11. Has child had previous evaluations or therapy? If so list:

Examination	When	Where	Examination	When	Where
Speech/Language	_____	_____	Hearing/Audiology	_____	_____
Eye/Ear	_____	_____	Physical Therapy	_____	_____
Psychiatric	_____	_____	Occupational Therapy	_____	_____
Neurological	_____	_____	Psychological	_____	_____
(EEG)	_____	_____	Intellectual/Academic	_____	_____

12. Date of most recent physical examination: _____ Physician: _____

13. Please indicate any relative in the immediate or extended family with any of the following:

Visual Acuity Problems	_____	Physical handicaps	_____
Strabismus/Ambliopia	_____	Hearing loss or deafness	_____
Blindness	_____	Speech or language problems	_____
Emotional problems	_____	Bipolar or mood disorder	_____
Mental retardation	_____	Attention or hyperactivity	_____
Convulsions/Epilepsy	_____	Other problems	_____

Dyslexia, learning or academic problems _____

Other problems or handicaps? (If so, explain what type of problem and the relationship to the child of the party involved: _____
_____

School History

1. List all schools, including preschool, which the child has attended:
   _____ _____ _____
   _____ _____ _____
2. Age at entrance to first grade: _____
3. Has a grade been repeated? _____ Explain: _____
4. Any school difficulties? _____ Explain: _____
   _____
5. Are teachers aware of the difficulties? _____ Are they helpful? _____
   Is schoolwork average? _____ Better than average? _____ Below average? _____
   What is best subject(s)? _____
   Poorest subject(s)? _____
   Does your child like to read? _____
6. Has your child ever had remedial or tutorial help? _____ Explain: _____

_____

7. List child's latest report card grades:
   Reading _____ Writing _____ Spelling _____ Mathematics _____
   Social Studies _____ Science _____ Effort _____ Art _____
   Phys. Ed. _____ Music _____ Behavior _____ Other _____
   Do you feel these grades are a fair reflection of your child's knowledge? _____

8. What are your expectations for this child (Jr. High, High School, College, Advanced Degree, Technical School, Other) _____

Emotional History and Behavior

1. Give a brief description of child's "personality". Begin by writing the one word which best describes the child. Please include your child's strengths and weaknesses.
   _____
   _____
   _____
   _____

2. Has child ever been given a psychological evaluation? _____ When? _____ By whom? _____
3. What is the best thing about your child? _____
4. What concerns you most about your child? _____
5. Is child primarily responsive: to people? _____ objects? _____
6. Is child especially alert to: movement? _____ noises? _____ touch? _____
7. Is child highly distractible? _____ hyperactive? _____ withdrawn? _____
8. Is child's behavior consistent from day to day? _____
9. Is child easily managed at home? _____ at school? _____
10. When fatigues, does your child sag? _____ become irritable? _____ become excited? _____
11. When placed under pressure or tension, is there any pattern of behavior, such as thumb sucking, nail biting, etc.? _____
12. In which activities is child most successful?
    _____
13. What are child's hobbies? _____
14. How does the child do with peers? _____
15. What is the relationship between father and child? _____
16. What is the relationship between mother and child? _____
17. What is the relationship between siblings and child? _____
18. Are there any family members with emotional, addictive or bipolar problems? _____
    _____

Family Information

1. Mother's Name: _____ Age: _____
   Address (if different from child):
   _____
   Street City State Zip Code
   Occupation: _____ Employer: _____
   Name Address
   Check highest level of education: _____ _____ _____
   High School/yr. College Degree/yr. Graduate school/yr.

2. Father's Name: _____ Age: _____

Address (if different from child):

_____

Street City State Zip Code

Occupation: _____ Employer: _____

Name Address

Check highest level of education: _____ _____ _____

High School/yr. College Degree/yr. Graduate school/yr.

3. Marital Status: Married _____ Separated _____ Divorced _____ Widowed _____

4. Has any separation between parent or parents and child ever taken place during the child's lifetime?
   Explain: _____

5. List names of brothers and sisters, and ages: _____
   _____

6. Which of these children are living at home: _____
7. List names and relationship of other persons living in the home: _____
8. Hours per week mother works? _____ Hours per week father works? _____
9. Who cares for children while parents are at work: _____
10. Nearest relative: _____ Address: _____
11. Person to contact in case of emergency if parents cannot be reached:
    _____

12. Please add any additional comments you feel would be helpful:
    _____

Person completing this form: _____ Date: _____