CHILDREN'S THERAPY T.E.A.M.

New Patient Pre-Evaluation Packet

please complete and return this packet prior to your child's evaluation

Child's Name: _____ **Child's Date of Birth:**_____

Today's Date:_____ **Legal Guardian (PRINT):**_____

Required Authorizations and Notices

Authorization for Evaluation and Treatment

I authorize physical therapy, speech therapy, developmental therapy, occupational therapy, orthotic equipment, and/or communication device evaluation(s) and treatment for the above said child.

Payment Authorization and Financial Agreement

I authorize payment of medical benefits to be made directly to Children's Therapy TEAM for services rendered. I agree to either fully pay or set up a payment plan and begin payment for all charges within 30 days of the receipt of my child's patient statement. I agree to be fully responsible for charges, regardless of my insurance company's coverage or lack of coverage of charges. Failure to pay outstanding balances will result in additional charges for collection and/or attorney's fees. Delays in providing updated insurance and payment information to Children's Therapy TEAM may result in denial of coverage by funding sources. Children's Therapy TEAM's policy limits the dates of backdated changes in claim or payment (insurance) information to 60 days prior to the date TEAM is notified of the change.

Parent Handbook Notices and Policies Agreement

I acknowledge that I have access to Children's Therapy TEAM's **Parent Handbook** through www.childrenstherapyteam.com or I may request a personal copy. I agree to follow the guidelines and policies set forth by Children's Therapy TEAM noted in their: HIPAA Privacy Practice Notices, Attendance Policies, Sick Policies, Inclement Weather Policy, Sibling Policies, Aquatic Therapy Policies, Parent Communication Policies, and Discharge Policies.

Notice of Status as a Teaching Facility

I acknowledge the status of Children's Therapy TEAM as a teaching facility. Students around the region periodically observe clinic operations and treatment sessions.

Medical Consent

I authorize the administration of first aid and/or CPR, as deemed necessary by staff members of Children's Therapy TEAM. Additionally, 911 will be contacted in serious medical emergencies, as deemed necessary by employees of Children's Therapy TEAM. Employees of Children's Therapy TEAM will contact me as soon as possible to inform me of the medical emergency.

Transportation Consent

I authorize employees of Children's Therapy TEAM to transport the said child to and from the treatment or rehab site to my home address or other designated location if the parent or transportation provider is unable to provide transportation due to an emergency.

Notice of Treatment by Other Providers

My child has received, within the last 12 months, a therapy evaluation or therapy services from a provider outside of Children's Therapy TEAM. ____YES ____NO

*If YES, what services were received/where were they received?*_____

_____

I have read and agree to the required authorizations, consents, and acknowledgments noted above.

_____ _____

Signature Date

Required for Aquatic Therapy

Aquatic Liability Release and Assumption of Risk

I acknowledge the risks related to the use of an aquatic environment to provide therapy, particularly the risk of drowning if a therapist for any reason becomes incapacitated while providing one-on-one therapy. I understand that this risk can be minimized with careful parent/caregiver supervision as there is no lifeguard on duty.

I hereby, intending to be legally bound, for myself, my heirs, assigned executors or administrators, waive and release forever all claims for damages against Children's Therapy TEAM, its board of directors, instructors, therapists, aides, volunteers and/or employees, the pool owner, their board of directors, management, employees, aids and volunteers for any and all injuries and/or losses that I, assisting guardians, assisting caregivers and/or my son/my daughter/my ward may sustain while in the aquatic environment for therapy (or any activity) provided by and/or sponsored by Children's Therapy TEAM.

_____ _____

Signature Date

Secure, Encrypted Email Notice

Children's Therapy TEAM can send secure/encrypted email correspondence. To register, parents receive a ZixCorp Secure Email Message. Follow the instructions in the email to set-up an account. Once set-up, parents can login to their account anytime to compose and send secure messages. Any information sent using our secure, encrypted email system may be read, printed and added to your child's medical record by Children's Therapy TEAM employees.

Risks of Unencrypted Email & Text

It is our duty to notify you of the risks of using unencrypted email and texts. These risks include, but are not limited to, the following:

- Information may be intercepted, viewed, altered, forwarded, stored in numerous forms, or used by unintended individuals without detection or authorization.
- Information may be sent to the wrong address/phone number.
- Texts and emails are easier to forge than handwritten or signed papers.
- Copies of texts and emails may exist even after the sender or the receiver has deleted his or her copy.
- Some service providers may have a right to archive and inspect information sent through their systems.
- Delivery is not guaranteed.
- Text and email can be used for Phishing. Phishing is a technique of obtaining sensitive personal information from individuals pretending to be a trusted sender. **Do not share highly sensitive information** such as a date of birth, login information, mother's maiden name, social security numbers, banking information or other highly sensitive information via unsecured text or email.
- Email can spread computer viruses.

Parent Choice Text & Email

HIPAA now gives patients choices regarding how they wish to communicate with their medical providers. By acknowledging the risks (noted above), you may elect to use unencrypted, non-secure email and text to both give and receive patient health information.
____*YES ____NO
*Note: Please discuss preferred communication options with your therapist. Use of text may vary from one therapist to another.

Voice Mail Preference

May we leave detailed messages which may include confidential patient health information? ____YES ____NO

eNewsletters and eEvent Notices

Would you like to receive eNewsletters and eEvent Notices from Children's Therapy TEAM? ____YES ____NO

If yes, please note preferred email address: _____.

Interaction with Student Clinicians under the Supervision of a Licensed Therapist

I, the legal parent/guardian of the above said child, support Children's Therapy TEAM in their role as a teaching facility. I give permission for my child to receive services rendered by a student clinician (those completing fieldwork as part of their graduate program in PT, OT, ST, or DT) under the direct supervision of a licensed therapist. ____YES ____NO

Instructional Use Authorization to Photograph/Video

I, the legal parent/guardian of the above said child, give Children's Therapy TEAM the right and privilege to photograph/video my child for educational and instructional purposes. I understand that videos and/or photographs of my child may be viewed and discussed during instructional classes (sometimes web-based), in medical journals/e-journals, in medical books/e-books and on instructional posters/e-posters.
____YES ____NO

Promotional Use Authorization to Photograph/Video

I, the legal parent/guardian of the above said child, give Children's Therapy TEAM the right and privilege to photograph/video my child for the use of developing and publicly releasing promotional information. I understand that my child's image may be viewed in the form of magazines, picture slideshows, posters, television, commercials and/or electronic media. ____YES ____NO

Authorization to Administer Medication

____YES ____NO If yes, please administer the following medications as needed:

_____

_____

_____

**Please note the dosage and the reason for administration of the medication.*

I have fully read the notices, consents and authorizations noted above.

_____ _____

Signature Date

HIPAA Authorization

Child's Name:_____ DOB:_____

Authorization to Release or Obtain Information

I hereby authorize Children's Therapy TEAM (DBA Children's Therapy TEAM) to release or obtain my child's individually identifiable information, including contact information, information about physical or mental health, information about health care services, information about education services and information about payment for services under the circumstances described below.

Purpose *(check one or more)*

☐ at the request of the parent/guardian
☐ for Health Care Services

Release

Disclosure TO/FROM (circle one or both)_____

Disclosure TO/FROM (circle one or both)_____

*Type of information to be disclosed in oral or written form: _____
_____
_____
_____
_____
_____

*NOTE: If this authorization is used for psychotherapy notes, it may not be used for any other type of information.

I understand that:

- This authorization must be filled out completely. A copy is as valid as the original.
- Children's Therapy TEAM will not refuse to provide health care services to me, based on my refusal to authorize the use or disclosure of my child's personal health information for purposes unrelated to those health care services.
- I may revoke this authorization at any time by notifying Children's Therapy TEAM in writing, but if I do, it won't affect any actions Children's Therapy TEAM took in reliance of this authorization before I revoked it.
- Once information is released to a third party according to this authorization, Children's Therapy TEAM cannot prevent its re-disclosure.
- This authorization does not limit the ability of Children's Therapy TEAM to use or disclose my child's health information as otherwise permitted by state and federal law.

PRINT Parent/Legal Guardian's Name:_____

Parent/Legal Guardian's Signature:_____Date:_____

Expiration Date 1 year from date signed, unless an earlier date is provided here:_____

You are entitled to a copy of this authorization form.

CHILDREN'S THERAPY T.E.A.M.

Face Sheet

Child's Name:_____ Date of Birth:_____
Today's Date: _____Evaluation Date:_____

Parent/Guardians Names: _____
Employer(s):_____

Parents' Dates of Birth:_____
Address:_____
City:_____ State:_____Zip Code: _____

Name of Emergency Contact (other than the parent): _____
Emergency Contact Phone Number:_____

Communication Preferences:

Please mark phone preferences as: (1) use first, (2) use as back-up, (X) do not use

_____ Home Phone Number_____
_____ Father's Employer Phone Number_____
_____ Mother's Employer Phone Number_____
_____ Father's Cell/Text Number_____
_____ Mother's Cell/Text Number_____
_____ Other Cell/Text Number_____relation:_____

Please mark email preferences as: (1) use first, (2) use as back-up, (X) do not use

_____ Mother's email address_____
_____ Father's email address_____
_____ Other email address_____relation:_____

Physician:

Primary Care Physician:_____Clinic:_____

Diagnosis:

My Child's Primary Diagnosis:_____
My Child's Secondary Diagnosis:_____
Who diagnosed your child?_____ Date of diagnosis:_____

Primary Insurance:

Insurance Policy Name: _____ Policy Number: _____
Group Number: _____Insured's Name:_____
Insured's DOB:_____Insured's Place of Employment:_____

Secondary Insurance:

Insurance Policy Name: _____ Policy Number: _____
Group Number: _____Insured's Name:_____
Insured's DOB:_____Insured's Place of Employment:_____

Tertiary Insurance:

Insurance Policy Name: _____ Policy Number: _____
Group Number: _____Subscriber's Name:_____
Insured's DOB:_____Insured's Place of Employment:_____

Medicaid, Tefra, and/or ARkids Number:_____

CHILDREN'S THERAPY T.E.A.M.

Case History

Child's Name:_____ Date of birth:_____

Sex: male / female Child's Address:_____

Today's Date:_____

NOTE: *Children's Therapy TEAM requests this information for the sole purpose of completing your evaluation. Completion of this case history is required prior to your scheduled evaluation. Failure to provide the information may result in an incomplete examination or cancellation of the assessment. If applicable, also submit or authorize TEAM to request on your behalf: a copy of recent hearing/vision test results, a copy of his/her IEP or 504, a copy of previous therapy evaluations.*

A. Has your child had his/her hearing and vision tested? **Yes / No**
If *yes,* where, when, and what were the results?_____
_____
_____

B. What services are you requesting? *(check all that apply)*

- O Occupational Therapy
- O Speech Therapy
- O Physical Therapy
- O Aquatic/Pool Therapy
- O Developmental Therapy (only for birth to age three)
- O Behavioral Consultation

C. Has your child participated in Occupational, Physical, Speech, ABA and/or Developmental Therapy in the past? **Yes / No**

If *yes,* please note which therapies were received, as well as their frequency?
_____
_____
_____

D. Therapy Precautions

Questions	YES	NO	Comments
1. Does your child have any food allergies?			*Please list allergies:*
2. If your child has Down Syndrome, has he/she been diagnosed with Atlantoaxial instability?			
3. Are there any precautions not listed above that we should know about? (latex allergies, dietary restrictions, etc.)			*Describe:*

E. Family & Social History

Father's Name:_____Age:_____ Occupation:_____
Mother's Name:_____Age:_____Occupation:_____

Is the client adopted? **Yes / No** If *yes,* at what age and from where/what country was he/she adopted?_____
Who lives in the house with this child, other than the parents? Please list the names and ages of children.
_____
Have there been any instances of the following in your immediate or extended family members:

- O ADHD
- O Learning Disabilities
- O Communication Disorders
- O Hearing Loss
- O Stuttering
- O Autism/PDD

Are there currently any stressful situations in the home or family?_____
Is there any history of abuse?_____

F. Pregnancy and Birth History

Questions	YES	NO	Comments
1. Were there any illnesses, bleeding, or other complication during this pregnancy?			*Describe:*
2. Was there any substance exposure in utero (e.g. alcohol, tobacco, doctor prescribed medications, other drugs)?			*Describe:*
3. Was this pregnancy full term?			If "no", what was your child's gestational age at time of delivery?
4. Was labor and delivery normal?			*If "no" please describe:* birth weight:_____ birth length: _____ *Was the birth vaginal, breech or cesarean?*
5. Did the child feel stuck in one position?			
6. Were forceps or a vacuum extractor used?			
7. Did your child experience jaundice?			
8. Was there a need for oxygen or respiratory assistance?			*Describe:*
9. Were there difficulties feeding?			*Describe:*
10. Was your child breastfed (or currently breastfeeding)?			*If "yes", how long?* *Any breastfeeding problems related to the baby's difficulty turning his/her head to nurse?*
11.Did your child have sucking difficulties?			*Describe:*
12. Does this child have biological siblings?			*How many siblings?*_____ Which pregnancy was this child?_____
13. Are there issues with sleep problems?			*Describe:*

G. Has your child had any of the illnesses, conditions and/or medical equipment below?

Illness/ condition/ apparatus	YES	NO	Comments
1. Meningitis			
2. Chicken Pox			
3. Seizures			
4. Frequent ear infections			
5. P.E. tubes			
6. Excessive vomiting or reflux			
7. Irritability/fussiness following feeding?			
8. Swallowing difficulties (current or previous)			
9. Cleft palate			
10. Vision problems			
11. Adaptive equipment			

Please list current and past medications. _____
_____
_____
_____
_____

Please describe any pertinent medical condition not mentioned above (accidents, injuries, etc.).
_____
_____
_____
_____
_____

Please provide the dates and descriptions of surgical procedures (if any).
Date:_____ Surgery:_____Description:_____

Date:_____ Surgery:_____Description:_____

Date:_____ Surgery:_____Description:_____

Date:_____ Surgery:_____Description:_____

Date:_____ Surgery:_____Description:_____

Date:_____ Surgery:_____Description:_____

Date:_____ Surgery:_____Description:_____

For additional surgeries use back as needed.

H. At what age did your child achieve the skills below?

Developmental Skill	Age achieved	Not yet achieved	Comments
1. Roll from stomach to back			
2. Roll from back to stomach			
3. Crawl			
4. Cruise around furniture			
5. Walk independently			
6. Speak first words			
7. Speak two word sentences			
8. Drink from a cup			
9. Use a spoon			
10. Dress independently			
11. Sit independently			
12. Toilet trained			
13. Toilet trained through the night			

I. Can your child display any of the physical skills below?

Skill	YES	NO	N/A	Comments
1. Jump up and down				
2. Hop on one foot				
3. Climb/descend stairs using alternate feet				
4. Skip				
5. Catch a ball				
6. Kick a ball				

J. Describe your child's behavior below.

Questions	YES	NO	N/A	Comments
1. My child is overly active.				
2. My child is mostly quiet.				
3. My child talks constantly.				
4. My child is impulsive.				
5. My child is frequently irritable.				
6. My child is stubborn.				
7. My child is resistant to change.				
8. My child overreacts.				
9. My child fights frequently.				
10. My child is usually happy.				
11. My child has frequent temper tantrums.				
12. My child is clumsy.				
13. My child has difficulty separating from caregiver.				
14. My child has nervous habits or tics.				
15. My child has a poor attention span.				

Questions	YES	NO	N/A	Comments
16. My child is frustrated easily.				
17. My child has fears.				If "*yes*", please describe.
18. My child rocks himself/herself frequently.				
19. My child shows difficulty learning new tasks.				
20. My child avoids touch.				
21. My child craves touch. He/she seeks it out.				
22. My child is shy.				
23. My child is typically compliant.				
24. My child tires easily.				
25. My child is easily managed at home.				Who manages your child best?
26. My child empathizes with others' feelings easily.				
27. My child understands punishment and easily shows remorse.				
28. My child understands praise and reward.				
29. My child recognizes danger.				
30. My child is affectionate toward familiar adults.				
31. My child is affectionate toward strangers.				
32. My child has friends.				

K. Describe your child's communication below.

Communication skill	YES	NO	N/A	Comments
1. My child understands simple directions.				
2. My child can identify body parts.				
3. My child recognizes pictures and objects.				
4. My child turns his/her head when his/her name is called.				
5. My child communicates with intent.				
6. My child answers "wh" questions.				
7. My child has hearing loss.				
8. My child hears and/or uses another language other than English at home.				If "*yes*", which language(s)?

How does your child communicate at home (PECS, augmentative/alternative communication device, American Sign Language, gestures, verbal)?

_____

_____

_____

_____

How many words are in your child's speaking vocabulary? _____under 25 _____ 25-75 _____over 75

How many words can your child understand? _____under 25 _____ 25-75 _____over 75

Please describe any communication difficulties/concerns.

_____
_____
_____
_____

When were problems *(if present)* first observed? _____

L. Describe your child's educational background below.

Education	YES	NO	N/A	Comments
1. Does your child attend school/preschool/childcare?				*If "yes",* what school/center does your child attend?
2. Does your child receive special education or therapies in his/her school or center?				*If "yes",* what is the frequency of OT, ST, & PT sessions? How long are the sessions? Are they group or individual sessions?
3. May we communicate with your child's school or center staff? (If *yes,* please complete the *HIPAA Authorization* on page 5)				
4. Has your child ever repeated a grade?				*If "yes",* which one?

What grade or age level setting is your child in right now?

_____

What is his/her current teacher's name(s) and phone number?

_____

If applicable, what are his/her therapists' names and phone numbers?

_____

M. What are your greatest concerns?

1. How concerned are you with your child's fine motor movement (movement with hands, etc.)?

extremely concerned	very concerned	moderately concerned	mildly concerned	not concerned
5	**4**	**3**	**2**	**1**

2. How concerned are you with your child's gross motor movement (full body movement)?

extremely concerned	very concerned	moderately concerned	mildly concerned	not concerned
5	**4**	**3**	**2**	**1**

3. How concerned are you with your child's speech and language development?

extremely concerned	very concerned	moderately concerned	mildly concerned	not concerned
5	**4**	**3**	**2**	**1**

4. How concerned are you with your child's sensory behaviors?

extremely concerned	very concerned	moderately concerned	mildly concerned	not concerned
5	**4**	**3**	**2**	**1**

5. How concerned are you with your child's social behavior?

extremely concerned	very concerned	moderately concerned	mildly concerned	not concerned
5	**4**	**3**	**2**	**1**

6. How concerned are you with your child's mobility?

extremely concerned	very concerned	moderately concerned	mildly concerned	not concerned
5	**4**	**3**	**2**	**1**

7. How concerned are you with your child's feeding?

extremely concerned	very concerned	moderately concerned	mildly concerned	not concerned
5	**4**	**3**	**2**	**1**

8. Are you concerned about your child's progress at school?

extremely concerned	very concerned	moderately concerned	mildly concerned	not concerned
5	**4**	**3**	**2**	**1**

Describe your concerns: