THERA-play PEDIATRICS

Your Child's Evaluation Packet

Instructions:

Complete and return this packet prior to your child's evaluation.

If applicable, also submit:

- A copy of recent hearing/vision test results,
- A copy of his/her IEP or 504,
- A copy of previous therapy evaluations,
- Any additional information your therapist may request.

Packet Content:

Part 1: Face Sheet

Part 2: Case History

Part 3: HIPAA Authorization

Part 4a and 4b: Authorizations, Acknowledgements, Agreements

NOTE: Thera-Play requests this information for the sole purpose of completing your child's evaluation. Completion of this case history is required prior to your scheduled evaluation.
Failure to provide the information will result in an incomplete examination or cancellation of the assessment.

Part 1: Face Sheet

Child's Name: _____ Date of Birth: _____

Today's Date: _____Reevaluation Date: _____

Parent/Guardians Names: _____

Contact Information:

Father's email(s):_____Mother's email(s):_____

Address: _____

City: _____ State: _____Zip Code: _____

Home Phone Number: _____

Father's Cell: _____Mother's Cell:_____

Father's Employer: _____

Work Number: _____

Mother's Employer: _____Work Number:_____

Emergency Contacts:

Emergency Contact (1):_____ Phone: _____

Emergency Contact (2):_____Phone:_____

Physician:

Primary Care Physician:_____Clinic:_____

Primary Care Physician Phone Number: _____

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: _____

Insurance Phone #:_____Contact Person: _____

Claims Address:_____

City: _____State:_____Zip:_____

Secondary Insurance:

Insurance Policy Name: _____ Policy Number: _____

Group Number: _____Insured's Name: _____

Insured's DOB: _____Insured's Place of Employment: _____

Insurance Phone #:_____Contact Person: _____

Claims Address:_____

City: _____State:_____Zip:_____

State Funding Sources:

Medicaid Number: _____Effective Date: _____

TEFRA Number:_____Effective Date:_____

AR Kids A Number:_____Effective Date:_____

AR Kids B Number:_____Effective Date:_____

Part 2: Case History

Child's Name:_____ Date of birth:_____

Gender:_____

Child's Address:_____

A. Would like the results of your child's evaluation to be sent to anyone other than

yourself? _____Yes/No

If "yes," to whom would you like the re-evaluations sent (include contact information)?

_____

_____

_____

B. Has your child had his/her hearing and vision tested?_____ Yes/No

If yes, where, when, and what were the
results_____

_____

_____

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

- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Physical Therapy

D. Has your child participated in Occupational, Physical, Speech in the past?_____ Yes/No

If "**yes**," which therapies, where were they received, and what was the frequency?

E. 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, food allergies, etc….)			Describe:

F. 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:

☐ ADHD ☐ Hearing Loss

☐ Stuttering ☐ Learning Disabilities

☐ Autism/PDD ☐ Communication Disorders

Are there currently any stressful situations in the home or family? _____

Is there any history of abuse? _____

G. Pregnancy and Birth History

Questions	Yes	No	Comments
1. Were there any illnesses, bleeding, or other complications during this pregnancy?			Describe:
2. Was this pregnancy full term?			If no, what was your child's gestational age and weight at time of delivery?
3. Was labor and delivery normal? 3a. Birth Weight_____ 3b. Was delivery vaginal or cesarean? _____			
4. Did the child feel stuck in one position?			
5. Were forceps or a vacuum extractor used?			
6. Did your child experience jaundice?			
7. Was there a need for oxygen or respiratory assistance?			Describe:
8. Were there difficulties feeding?			Describe:
9. Was your child breastfed (or currently breast feeding)?			If "yes" how long? Any breastfeeding problems related to the baby's difficulty turning their head to nurse?
10. Did your child have sucking difficulties?			Describe:
11. Does this child have biological siblings?			How many siblings? _____ Which pregnancy was this child? _____
12. Are there issues with sleep problems?			Describe:

H. Has your child had any of the illnesses, conditions and / or medical conditions below:

ILLNESS/ CONDITION	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 medical condition not mentioned above (accidents, injuries, surgeries, etc.)

_____
_____
_____

Please provide the dates and descriptions of surgical procedures (if any)

Date: _____ Surgery: _____ Description: _____
Date: _____ Surgery: _____ Description: _____
Date: _____ Surgery: _____ Description: _____

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

Developmental Skills	Age Achieved	Not yet Achieved	Comment
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			

J. 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				

K. 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 restless				
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				
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 rewards				
29. My child recognizes danger				
30. My child shows concern when separating from parents				
31. My child is affectionate toward familiar adults				
32. My child is affectionate towards strangers				
33. My child has friends				

L. Describe your child's communication below.

Communication Skill	YES	NO	N/A	Comments
1. My child understands simple direction				
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				
Communication Skills	**YES**	**NO**	**N/A**	**Comments**
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 did you first observe any problems (if present)? _____

M. Describe your child's educational background below.

Educational Background	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?				
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)?

_____

_____

If applicable, what are his/her therapists' name(s)?

_____

_____

N. How concerned are you with the following?

Read the questions and check the appropriate box	Extremely Concerned	Very Concerned	Moderately concerned	Mildly Concerned	Not Concerned
1. Your child's fine motor movement (movement with hands, etc)?					
2. Your child's gross motor movement (full body movement)?					

3. Your child's speech and language development?					
4. Your child's sensory behaviors?					
5. Your child's social behaviors?					
6. Your child's mobility?					
7. Your child's feeding?					
8. Your child's progress at school?					

Please describe any additional concerns or comments you may have that were not discussed in the information above.

_____
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Part 3: HIPAA Authorization

This authorization will expire one year from the date signed unless an earlier date is provided here:_____

Child Name: _____DOB: _____

I hereby authorize Thera-Play Pediatrics to release or obtain my individually identifiable information,

Including; contact information, pictures of my child, information about physical health and/or mental

health, physical or mental condition, healthcare or other services, and payment for services.

I understand that:

- **I am entitled to a copy of this form.**
- **A copy of this permission form is as valid as the original.**
- **I may revoke this authorization at any time by notifying Thera-Play Pediatrics in writing. This will not affect any action Thera-Play Pediatrics took in reliance on this authorization before it was revoked.**
- **If I refuse to authorize disclosure of my child's unrelated healthcare information, then Thera-Play Pediatrics will not deny services.**
- **Once information is released to a third party according to this authorization, Thera-Play Pediatrics cannot prevent its re-disclosure.**
- **This authorization does not limit the ability of Thera-Play Pediatrics to use or disclose my child's health information as otherwise permitted by the state and federal law.**
- **Disclosed information may be oral or written.**

Print Parent/Legal Guardian's Name: _____

Describe Relationship to Patient: _____

Parent/Legal Guardian's Signature: _____ Date: _____

RELEASE:

Disclosure to: _____

Disclosure from: _____

Date: _____

Type of information:

_____

_____

Part 4a: Authorizations, Acknowledgements, Agreements

Child's Name: _____ Date of Birth:_____

1. Authorization for Evaluation and Treatment

I, authorize physical (including orthotics), speech, and/or occupational evaluations(s) and treatment for the above said child as ordered by my child's physician.

_____ _____

Signature **Date**

2. Authorization for Release of Medical Information

I, the legal parent/guardian of the above said child, do hereby give my permission to Thera-Play Pediatrics to use my child's medical records for any purpose deemed necessary.

_____ _____

Signature **Date**

3. Authorization to Photograph/Video for Promotional and/or Instructional Use

I, the legal parent/guardian of the above said child, give Thera-play Pediatircs the right and privilege to photograph/video my child for the use of developing and publicly releasing promotional information or for educational and instructional purposes. I understand that my child's image may be viewed in the form of magazines, journals, medical journals, books, posters, television, instructional posters, commercials and/or internet web pages.

_____ _____

Signature **Date**

4. Payment Authorization and Financial Agreement

I authorize payment of medical benefits to be made directly to Thera-Play Pediatrics 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.

_____ _____

Signature **Date**

5. Lifesaving Consent

If I, the legal parent/guardian, cannot be reached, I authorize the administration of "life saving" procedures such as x-rays, surgery, transportation, hospitalization, medication, and/or treatment procedure deemed necessary by a medical professional.

_____ _____

Signature **Date**

6. Transportation Consent

I authorize employees of Thera-Play Pediatrics to transport the said child to and from the treatment or rehab site to my home address or child's school.

_____ _____

Signature **Date**

8. Consent for Child Observation and Intern/Student Interaction

I, the legal parent/guardian of the above said child, understand that Thera-Play Pediatrics is a teaching facility. I give permission for my child to be observed through supervised observation undertaken as part of an academic internship, practicum, and/or observation requirement for students. Interns may be used in a support capacity or as administrative assistants. They may participate in partner activities with my child while his/her therapist is in direct supervision.

_____ _____

Signature **Date**

Part 4b: Authorization to Administer Medication

Directions: If you would like Thera-Play staff to administer any prescription OR over the counter Medications, while under the supervision of his/her therapist, please complete the form below**.**

Child's Name: _____Child's DOB: _____

Today's Date: _____

#1) Name of Medication:

_____

Form of Medication/Treatment:

Tablet/Capsule Liquid Inhaler Injection Nebulizer Other

Instructions (schedule and dose to be given during therapy):

_____

_____

Is the medication for episodic/emergency events only? _____ Yes/No
Are there any restrictions and/or important side effects? _____ Yes/No
If "Yes," please describe:

_____

_____

#2) Name of Medication:

_____

Form of Medication/Treatment:

Tablet/Capsule Liquid Inhaler Injection Nebulizer Other

Instructions (schedule and dose to be given during therapy):

_____

_____

Is the medication for episodic/emergency events only? _____ Yes/No
Are there any restrictions and/or important side effects? _____ Yes/No
If "Yes" please describe:

_____

I give authorization for Thera-Play staff to administer the medications noted above.

Parent or Guardian Signature_____Date_____