NORTH RIVER
THERAPY

PEDIATRIC INTAKE FORM

PATIENT INFORMATION

LAST NAME:	FIRST:	D.O.B:	SEX: M / F
HOME ADDRESS:	CITY:	STATE:	ZIP CODE:	HOME PHONE:

PARENT INFORMATION

MOTHER'S LAST NAME:	FIRST:	FATHER'S LAST NAME:	FIRST:
MARITAL STATUS: SINGLE ( ) MARRIED ( ) OTHER ( )			

REFERRING PHYSICIAN INFORMATION

LAST NAME:	FIRST:	NAME OF FACILITY:	TELEPHONE:

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

LAST NAME:	FIRST:	CELL PHONE:	WORK PHONE:
HOME ADDRESS:	CITY:	STATE:	ZIP:
RELATIONSHIP: ___EMERGENCY CONTACT ____PARENT ____GUARDIAN			

REASON FOR TODAY'S VISIT

DATE OF INJURY: _____ NEXT DOCTORS VISIT: _____

DIAGNOSIS: _____

DESCRIBE THE CURRENT SYMPTOMS: _____

Educational/Daycare History:

What daycare or school does your child attend? _____ Current grade level_____

How often does he/she attend school? _____ days per week_____ hours per day_____

What are your child's strengths in school? _____
_____
_____

What areas at school are the most difficult for your child? _____
_____
_____

NORTH RIVER THERAPY

PEDIATRIC MEDICAL HISTORY

BIRTH INFORMATION (CHECK ALL THAT APPLY):

COMPLICATIONS/HEALTH PROBLEMS DURING PREGNANCY:

Diabetes____ Strep____ Premature Labor____ Measles____ Respiratory____ Toxemia____

Other: _____

COMPLICATIONS DURING LABOR/DELIVERY (CHECK ALL THAT APPLY):

Cesarean Section____ Emergency____ Forceps____ Vacuum____ Other: _____

DESCRIBE CHILD'S CONDITION AT/OR IMMEDIATELY AFTER BIRTH (CHECK ALL THAT APPLY):

Premature____(If yes) Gestational age_____ Jaundice____ NICU____ Poor Suck____

Ventilator____ (If yes) How Long? _____ Heart Problems____ Apgar's____

Small for Gestational Age____ Large for Gestational Age____

Known Diagnosis (e.g. Down's Syndrome) _____

Other Medical Complications_____

CHILD'S MEDICAL HISTORY (CHECK ALL THAT APPLY):

Measles____ Head Injuries____ Pneumonia____ Allergies____ Mumps____

Tonsillitis____ BPD____ Chicken Pox____ Reflux____ Bronchitis____

Ear Infections____ Frequency: _____ Last Ear Infection: _____ Treatment Method: _____

List Any Hospitalizations Dates (from-to) _____

(PLEASE CIRCLE)

1. Does your child have asthma, hay fever, eczema, or rashes? YES NO
   If yes, please comment if necessary. _____
2. Does your child have any allergies? YES NO
   If yes, please state: _____

SURGERIES PERFORMED (CHECK ALL THAT APPLY):

Ear tubes_____ Still in Place? _____ Central Line_____ Spinal Infusions_____ Trach_____

G-Tube____ Heart Repair_____ Tonsillectomy_____ Appendectomy_____ Shunt_____

Other_____

TESTS PERFORMED (CHECK ALL THAT APPLY):

MRI____ CT Scan____ Genetic Testing____ X-Rays____ Other_____

PLEASE LIST CURRENT MEDICATIONS: _____

_____

_____

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PEDIATRIC DEVELOPMENTAL HISTORY

CHILD'S DEVELOPMENTAL HISTORY:

DEVELOPMENTAL MILESTONES: LIST THE APPROXIMATE AGE THE CHILD ACCOMPLISHED THE FOLLOWING:

Rolled Over____ Sat without support____ Crawled____ Stood alone____
Walked alone____ Held cup____ Open cup____ Used fork____
Dress/Undress self____ Button/Zip clothes____ Started solid food____
Drank from sippy cup____ Lift head while on tummy____ Hand Preference Left____ Right____
Dry during day____ Night____ Gain bowel control____
Does your child have any bladder or bowel difficulties? YES / NO
Please Describe_____

SPEECH: LIST THE APPROXIMATE AGE THE CHILD ACCOMPLISHED THE FOLLOWING:

Babble (dada, baba, etc.) ____ Said first words____ Combined words____
Does your child respond when his/her name is called? YES / NO
Follow simple directions? YES / NO
Approximately how many words does your child have? _____
How does your child tell you what he/she wants? _____

FEEDING: DOES YOUR CHILD HAVE ANY DIFFICULTY WITH THE FOLLOWING?:

Poor Suck____ Difficulty swallowing____ Difficulty chewing____ Gag/choke often____
Finger feeding____ Spoon use____ Required a feeding tube____ Reflux/vomiting____
List any other feeding concerns_____
Is your child a picky eater? YES / NO Does your child dislike particular textures of food? YES / NO
List any other feeding concerns: _____

HEARING/VISION:

Has your child ever had a vision test? YES / NO
If yes, last date performed_____ Results_____
Does your child wear glasses? YES / NO
Has your child ever had a Hearing test? YES / NO
If yes, last date performed_____ Results _____
Does your child wear a hearing aide? YES / NO If yes: Left_____ Right_____

SENSORY HISTORY:

Do your child's hands, feet, and or tummy seem overly sensitive to touch? YES NO
Does your child seem distractible or overactive? YES NO
If yes, please describe_____
Does your child tolerate tooth brushing? YES NO
Does your child hesitate on uneven surfaces? YES NO
Does your child have difficulty positioning him/her in a chair? YES NO
Does your child push/bump into other children? YES NO
Does your child seem generally weak? YES NO
Does your child have difficulty judging the height/depth of stairs? YES NO
Does your child walk/go down stairs heavily (stomping feet)? YES NO

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PATIENT AUTHORIZATION

RELEASE OF INFORMATION & CONSENT FOR TREATMENT

All information provided herein is true and correct.

I am aware of my child's diagnosis and wish him/her to receive treatment at North River Therapy. I permit its employees and all other persons caring for my child to treat him/her in ways they judge are beneficial to him/her. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care. I give permission to North River Therapy to release information, verbal and written contained in my child's medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related health care provider, assignees and/or beneficiaries and all other related persons to my child's treatment or payment for services provided. I authorize North River Therapy to obtain medical records and/or professional information from my child's physician or other medical professional as it relates to my child's treatment. The signature below certifies that I have read and understand the above information.

Signature: _____ Date: _____

FINANCIAL POLICY

Although we strive to obtain the most accurate information possible, the quoted benefits from your insurance company are not a guarantee of payment. Should you need the detailed information about your coverage, please contact your insurance company directly. **You are responsible for your insurance deductibles, co-payments and supplies at the time of service.** There is a $25 service charge for all checks returned. I understand that I am financially responsible to North River Therapy for any changes accrued during the course of treatment and verification of benefits does not guarantee payment by the insurance company. The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services. I hereby authorize payment to be made directly to North River Therapy.

I understand that it is my responsibility to pay out of pocket for any charges accrued while at North River Therapy due to an automobile accident. It is then my responsibility to coordinate the therapy bills with whomever is handling the automobile accident for possible reimbursement to me.

I understand that North River Therapy is not responsible for loss or damage to any personal valuables or properties.

_____ _____

Signature of Responsible Party Date

OUTPATIENT CANCELLATION POLICY

Please make all efforts to arrive for your child's Physical Therapy appointment on time. If you are unable to keep your appointment, please call and cancel so that we may adjust the therapist's schedule. We ask for at least a 24-hour notice for cancellations. No shows and cancellations less than 24 hours in advance will result in a $50 fee, which will be due and payable on your next visit. We are aware that emergencies occur, but would prefer a cancelled visit to a "no show." Thank you in advance for your cooperation in this matter.

Please sign to indicate awareness of this policy _____

Signature of Responsible Party Date

WAIVER FORM

I, _____ the parent or guardian of _____ give permission for my child to participate in North River Therapy's services. I hereby release North River Therapy's principal owners, therapists, employees and representatives and all other individuals or organizations acting on behalf of North River Therapy, from any and all claims which I or my child may have, resulting from or in connection with my child's participation in North River Therapy. This includes, but without limitation, any claim, demands or causes of action for injuries to my child, including but not limited to injuries resulting from the use of any play/therapy equipment during the service at North River Therapy. I understand that I should be present at all times during the service to my child. If I choose not to, I understand that the aforementioned statements still apply in my presence or absence during the services provided. This agreement is signed for the purpose of fully and completely releasing, discharging and indemnifying North River Therapy in connection with their programs from all liability as herein described.

Signed: _____

Parent or Guardian Signature Date