Pediatric Physical Therapy, LLC
881 Hillcrest Rd
Mobile, AL 36695

Patient Information

Name _____ Sex _____ Race_____
Date of Birth _____ Social Security Number _____
Address _____
City, State, Zip _____

Primary Contact

Name _____
Relationship To Patient _____
Date of Birth _____ SS# _____
Address _____
City, State, Zip _____
Phone _____
Employer _____
Work Phone _____
Primary Email:_____

Who to Notify upon Emergency – Secondary Contact

Name _____
Relationship To Patient _____
Date of Birth _____
Address _____
City, State, Zip _____
Phone _____
Employer _____
Work Phone _____

Guarantor Information – (PARENTS OR GUARDIAN)

Name _____ Relationship _____
Date of Birth _____
Social Security Number _____
DL Number _____
Address _____
City, State, Zip _____
Phone _____
Work Phone _____
Employer _____
Employers Address _____
Occupation _____

Insurance Information

Insured Person Name_____

Relationship to Patient _____

Date of Birth _____

Social Security Number _____

Phone Number _____

Primary Insurance _____
Phone Number _____
Policy Number _____
Group Number _____
Employer _____
Employers Address _____
Work Number_____

Secondary Insurance _____
Phone Number _____
Policy Number _____
Group Number _____
Employer _____
Work_____

AL Medicaid Information

Name as it Appears on Medicaid Card _____

Medicaid Number _____

Pediatric Physical Therapy, LLC
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Mobile, AL 36695
General Information & Medical History Form

Child's Name _____
Date of Birth _____ Sex _____
Address _____
City, State, Zip _____
Home Phone Number _____ Daytime Number _____
Referring Physician _____
Medical Diagnosis _____
Mother's Name _____
Father's Name _____
School _____ Grade _____
Height _____ Weight _____

Allergies:

- Allergies to Medications: _____
- Latex: Yes No Peanut: Yes No Other: Yes No
- Do you carry an Epi Pen for any of these allergies? Yes No
- Other Allergies _____

Please list all physicians who care for your child	Date Last Seen
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Has your child recently experienced any of the following?

Yes No Weight loss or gain
Yes No Nausea / Vomiting / Diarrhea
Yes No Fatigue
Yes No Unusual Weakness
Yes No Fever / Chills / Sweats
Yes No Numbness / Tingling

Has your child EVER been diagnosed as having any of the following?

Yes No Cancer
Yes No Heart Problems
Yes No High Blood Pressure
Yes No Asthma / Breathing Problems
Yes No Thyroid Problems
Yes No Diabetes
Yes No Arthritis
Yes No Depression
Yes No Hepatitis

Yes No Tuberculosis
Yes No Stroke
Yes No Kidney Disease
Yes No Anemia
Yes No Epilepsy
Yes No Seizures
Yes No Cerebral Palsy
Yes No Muscular Dystrophy
Yes No Spina Bifida
Yes No ADD/ADHD
Yes No Other _____

List all surgeries, injuries, and hospitalizations

List all medications and dosages the child is currently taking

List all over the counter medications your child takes

List any recent Diagnostic Tests and the results: (MRI, CT scan, X-rays, Lab Work)

Has anyone in the child's immediate family (parents, brothers, sisters) been treated for any of the following?

Yes No Diabetes
Yes No Tuberculosis
Yes No Heart Disease
Yes No High Blood Pressure
Yes No Asthma / Breathing Problems
Yes No Stroke
Yes No Kidney Disease
Yes No Cancer
Yes No Arthritis
Yes No Anemia
Yes No Headaches
Yes No Epilepsy / Seizures
Yes No Mental Illness
Yes No Alcohol or Chemical Dependency

Birth History

Complications during pregnancy? Yes No If yes, please specify.

_____

_____

Premature Delivery Yes No If yes, how many weeks? _____
Birth weight _____ Mode of delivery _____
Immediate respiration? Yes No If no, please infer how long before respiration and or medical interventions required. _____
Complications during/after delivery? _____
NICU stay required Yes No If yes, how long? _____
Other _____

Postnatal History

Please list and describe any important injuries or illnesses that are not already listed including ear and chest infections (also indicate if hospitalization was required for any of these illnesses). At what ages did these occur?

_____

_____

_____

_____

Milestones

Roll over _____
Sit alone _____
Crawl – creep _____
Pull to standing _____
Cruise, walk with support _____
Walk alone _____
Run _____
Comments _____

_____

_____

_____

_____

Eating Habits: Please indicate all that apply
___ Tube Feeds
___ Eats by Spoon
___ Bottle Only
___ Self-feeds
___ NPO
___ Special Techniques
___ Other _____

Social History
Who does the child live with? _____
Are parent's married, separated, divorced, or deceased? _____
Does your home have stairs inside or to enter? _____
Do you have any family / living problems which you think might affect your child's developmental or therapy? Explain. _____
_____
_____

What does your child like? _____
_____

What does your child dislike? _____
_____

Does your child receive or have they received any other therapy, early intervention, and/or special education? _____
_____

Please indicate with a plus (+) the items that you feel are strengths in your child and a minus (-) to identify those which are a weakness in this child.

___ response to smells and tastes
___ response to visual stimuli
___ response to sound
___ response to touch
___ response to movement
___ response to eating
___ ability to manage physical / motor requirements of play/school
___ self-feeding
___ dressing
___ toileting
___ grooming
___ gross motor coordination
___ fine motor coordination
___ general activity level
___ attention span
___ social skills
___ motivation
___ response to family
___ response to other children

Comments _____
_____
_____

Does your child use glasses, hearing aids, braces, wheelchair or other special equipment for daily activities? _____
_____
_____

What functional problems is the child having at home? _____

_____

_____

_____

_____

Please describe your child's problem for which you are seeking physical therapy. _____

_____

_____

_____

_____

What would you like us to help you and your child do? _____

_____

_____

_____

_____

Person completing this form _____

Signature _____

Relationship to Patient _____

Date _____

Review of Systems. Please indicate any symptoms that your child is currently exhibiting by marking an X on the line in front of the symptom. Your therapist will assist with any areas that you are uncertain of the meaning.

I. **General Health**
- ___ Fatigue
- ___ Malaise
- ___ Fever Chills Sweats
- ___ Nausea Vomiting
- ___ Unexplained Weight Change
- ___ Numbness Paresthesia
- ___ Weakness
- ___ Change in Mental Status
- ___ Dizziness Lightheadedness

II. **Cardiovascular System**
- ___ Difficulty Breathing / Shortness of Breath
- ___ Requires Upright Positioning for Difficulty
- ___ Breathing
- ___ Heart Palpitation
- ___ Pain / Sweats
- ___ Fainting Spells
- ___ Edema in Extremities
- ___ Cough

III. **Pulmonary System**
- ___ Difficulty Breathing / Shortness of Breath
- ___ New Onset of Cough
- ___ Change in Cough
- ___ Change in Sputum
- ___ Blood in Sputum
- ___ Clubbing of Nails
- ___ Stridor
- ___ Wheezing

IV. **GI Systems**
- ___ Difficulty with Swallowing
- ___ Heartburn / Indigestion
- ___ Specific Food Intolerance
- ___ Change in Appetite
- ___ Bowel Dysfunction / Changes
  - _ Color
  - _ Frequency
  - _ Shape / Caliber
  - _ Constipation / Diarrhea
  - _ Difficulty Initiating
  - _ Incontinence

V. **Urinary Systems**
- ___ Change in Frequency
- ___ Change in Urgency
- ___ Incontinence
- ___ Reduced Caliber of Force of Urine Stream
- ___ Difficulty initiating Urine System
- ___ Color Changes
- ___ Difficulty Urinating

VI. **Reproductive Systems**

Male:
- ___ Urethral Discharge
- ___ Abnormal Swelling / Hernia

Female:
- ___ Vaginal Discharge
- ___ Change in Menstruation (As Applicable)
  - _ Age of Onset _____
  - _ Frequency & Length _____
  - _ Pain _____
  - _ Date of Last Period _____
  - _ Any Missed Periods _____

Person Completing this form _____
Signature _____
Relationship to Patient _____
Date _____

Form Reviewed by Therapist with Parent/Guardian Yes No Date _____

Therapist _____ Date _____

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THE UNDERSIGNED, ACKNOWLEDGE AND AGREE TO THE FOLLOWING:

CONSENT FOR PHYSICAL THERAPY TREATMENT I (for) the undersigned patient do hereby voluntarily consent to physical therapy including diagnostic procedures and treatment as considered necessary by my physical therapist. I am aware that the practice of medicine and physical therapy is not and exact science and I acknowledge that no guarantees have been made to me concerning the result of any treatments or examinations performed in therapy.

ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY I hereby authorize direct payment of benefits to Pediatric Physical Therapy, LLC. In consideration of the care and services to be rendered to he below named patient by the Pediatric Physical Therapy, LLC. I understand that I am legally and financially responsible to Pediatric Physical Therapy for all charges not paid by insurance. The undersigned agrees to pay other amounts herein provided, all costs and expenses of collection, including reasonable attorneys' fees.

MEDICARE / MEDICAID / CHAMPUS CERTIFICATION I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is complete and correct. I request that payment of authorized benefits be made on my behalf for any services furnished to me by or in Pediatric Physical Therapy, LLC.

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize Pediatric Physical Therapy, LLC to release all information including copies of records relating to this or any previous visits to the legal guardian, referring physician, consulting physician and PCP. Other records will only be released to those individuals whom the legal guardian gives written permission.

I have read this form and any questions that I have related to it have been answered. I understand that if I have questions regarding this consent form, I can have those questions answered by the owner or therapist of Pediatric Physical Therapy, LLC.

Date _____ Signature of Patient _____

Patient is a minor or unable to consent because _____
Signature of Parent, Legal Guardian, Authorized Agent or nearest Relative

_____

Relationship to Patient _____

Witness _____

Patient Name _____

Social Security Number _____

Date of Birth _____

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE
Notification of the Privacy Policy by Pediatric Physical Therapy, LLC.
I also acknowledge that I may have a copy of the privacy policy if required.

Signature of Patient or Patient's Representative _____
Printed Name of Patient's Representative _____
Representative's Relationship to Patient _____
Date _____

List family members with whom we can discuss patient history and treatment

_____

List family members with whom we can discuss patient's statement of account / billing information

_____

After a good faith attempt to obtain an Acknowledgment of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason:

_____
_____
_____

_____ _____

Signature of PPT, LLC Representative Date