

## PEDIATRIC THERAPY POLICIES



256.265.7952 phone 256.265.7953 fax

<u>Supervision:</u> An adult must accompany all children to their appointment. If your child is under 14 years old or has developmental delays, an adult must remain on the premises during the appointment. A parent or legal guardian must be present to sign for consent for treatment prior to your child's initial evaluation. The therapist will not be able to see the child without legal consent.

<u>Participation:</u> Parents/caregivers are expected to actively participate in therapy sessions with their child. This optimizes carry-over of activities and therapy techniques at home, and will help your child meet their therapy goals. There may be circumstances when this is not possible, and the therapist and caregiver agree that an alternative approach needs to be taken.

Siblings may be helpful during therapy sessions, or they may be distracting. It is at the therapist's discretion whether a sibling is permitted to stay in the therapy area. Another adult should be available if it is determined that the sibling needs to wait in the lobby. Please plan to have your other children supervised.

Other family members, friends, or babysitters may be involved in helping a child reach their goals. Space permitting, we welcome these support people to attend therapy sessions.

<u>Cancellations:</u> Please notify our office as soon as possible if you need to cancel your appointment so we may accommodate the needs of others. A call less than an hour prior to your appointment will be counted as a "no show." This "no show" will be counted in our "no show" policy. If you are finding you have to cancel on a regular basis, please speak with your therapist regarding a different day or time that may work better for you. Or speak to your therapist about putting therapy on hold until you can attend on a consistent basis.

<u>Tardiness:</u> It is very important for your child to arrive on time for his/her appointment. If you arrive late, their therapy session will end at the scheduled time, so as not to interfere with the next child's time. If you are more than 10 minutes late, it will be considered a "no show" and your appointment will be re-scheduled.

No Shows: Should you fail to show for a scheduled appointment, it will be documented in your child's chart. After two consecutive or three total "no shows," your child will be discharged from therapy. A letter will be sent to your child's physician's office to notify them. If, in the future, you wish to schedule therapy, you will be placed on our waiting list and will be scheduled when an appointment becomes available. A new physician's order or referral will be required to restart the program. This policy is necessary to accommodate patients who are waiting to be scheduled.

<u>Inclement Weather:</u> Pediatric Therapy follows Huntsville City Schools closings and delayed openings for inclement weather. If they close or open late due to weather, we will do the same.

<u>Insurance Coverage:</u> Please call your insurance carrier. Some insurance carriers require pre-certification for outpatient physical, occupational and speech therapy. If this is required and not done, they can deny payment for therapy. Please contact your insurance carrier to determine if this is required. Some insurance carriers may allow a limited number of therapy visits per year, or may not cover therapy at all. You will be responsible for payment for services not covered by your insurance.

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|--------------------------|------|-------------|
| Patient's Representative | Date | Time        |



## PEDIATRIC THERAPY & AUDIOLOGY CASE HISTORY FORM

| Services Requested: ( ) PT ( ) OT ( ) ST ( ) Audio   | Referring Pi<br>Diagnosis<br>Is your child<br>If yes, where<br>Family Info<br>Wi<br>Pa<br>Ho<br>Do | hysician:  I currently receiving the are they receiving the remation th whom does the child rents/Guardian phone notes and the contents are they are the are they are the are they are the they are the are they are the ar | herapy servi<br>erapy?<br>live? (providumbers           | ccs? () Yes   | Services P   | What T                                 | ype? ( ) PT   | ( ) OT ( ) ST |
|--|--|--|---|---|--|--|---------------|---------------|
| Is your child currently receiving therapy services? () Yes () No What Type? () PT () OT () ST of yes, where are they receiving therapy?  Family Information  With whom does the child live? (provide names)  Parents/Guardian phone numbers  Home Address  Does he/she have brother and sisters? () Yes () No Age of sibling(s):  Wedical History  Type of Delivery: () Vaginal Delivery () C-section () Vacuum () Forceps  Length of pregnancy () Full term, weeks () Pre-term, weeks  Any complications or infections (for example: CMV, herpes, rubella, syphilis, toxoplasmosis) during pregnancy of delivery?  Following birth, did the baby have difficulty, require extended hospitalization, special testing, or surgery?  Since birth, has the child been hospitalized or had surgery? () Yes () No  If yes, please list age at time of admission and reason for admission and any surgery done:  | Diagnosis<br>is your child<br>if yes, where<br>Family Info<br>Wi<br>Pau<br>Ho<br>Do                | t currently receiving the are they receiving the rmation the whom does the child rents/Guardian phone nome Address cs he/she have brother  | herapy servi<br>erapy?<br>live? (providumbers           | ces? ( ) Yes  | ( )No  | What Ty                                | ype? ( ) PT   | ( ) OT ( ) ST |
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| If yes, where are they receiving therapy?    Pamily Information  | if yes, where<br>Family Info<br>Wi<br>Pa<br>Ho<br>Do   | e are they receiving the rmation th whom does the child rents/Guardian phone nome Address es he/she have brother   | erapy?<br>live? (providumbers                           | de names)   |  |  |               |               |
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| If yes, please list age at time of admission and reason for admission and any surgery done:  | ***************************************  |  |   |   |  |  |               |               |
|  | Sir  | nce birth, has the child   | l been hospi  | talized or had s  | surgery? ( )   | Yes ( )                                | No            |               |
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| Date Reason for Hospitalization Surgery  |  | <u>Date</u>  |   | Reason for He   | ospitalization   |  | Surgery       |               |
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Patient Label



| At what age did your child:  Sit with assistance?  Crawf?  Cruise furniture?  Hold items with two hands?  Reach to get what they want?  Babble? (ex. Baba, awaba, etc.)  Say first word?  Lyse of variety of sounds in play?  Say first word?  Is your child toilet trained? ( ) Yes ( ) No If yes, at what age:  Please list your child's favorite toys  seeding/Swallowing  Is/was your child. ( ) Breast fed ( ) Bottle fed ( ) Both  For how long?  What kind of diet is your child currently on?  Does your child feed him/herself? ( ) Yes ( ) No  Does your child have any suspected swallowing problems? ( ) Yes ( ) No  Is he/she fed by alternative feeding, methods? (G-tube, Ng tube) ( ) Yes ( ) No  If yes, please specify  Has your child experienced recent weight gain? ( ) Yes ( ) No  ON OR weight loss? ( ) Yes ( ) No  Does your child require skilled oursing care in the home? ( ) Yes ( ) No   | Has your child ever been diagnosed with a     | ny of the following co  | nditions?  |  |
|--|---|---|--|--|
| ( ) Encephalitis ( ) Meningitis ( ) Cytomegalovirus (CMV) ( ) Contragious Diseases (Please include common childhood diseases) ( ) Ashtma ( ) Simas/Hergies: If yes, specify: ( ) Other Respiratory problems: If yes, specify: ( ) Cerebrovascular accident (Stroke) ( ) Cerebral Palsy: If yes, Type: ( ) Spina Biffied ( ) Cardiac (heart) problems: Specify: ( ) Pacamaker ( ) Defibrillator ( ) Failure to Thrive ( ) Gastrointestinal problems (ex: Reflux) Specify: ( ) Diabetes ( ) Genetic Syndrome: If yes, specify: ( ) Diabetes ( ) Blood disorder ( ) Genetic Syndrome: If yes, specify: ( ) Orthopedic injuries (ex: broken bones) Specify: ( ) Joint Condition/Arthritis ( ) Yorricolfis ( ) Skin Condition ( ) Pregnant ( ) Lactating ( ) Other  Has your child ever experienced seizures? ( ) Yes ( ) No If yes, when was the last time? It syour child ower had special testing done for the seizures? ( ) Yes ( ) No If yes, what testing, and what were the results?  Plopmental History  At what age did your child: First roll over? Sit with assistance? Sit alone?  Crusic furniture? Walk?  Paul to Stand?  Crusic furniture?  Hold idens with two hands? Pick things up?  Reach to get what they want?  Babble? (ex. Baba, awaba, etc.) Use of variety of sounds in play?  Say first word?  Does your child is favorite toys  Ending/Swallowing  Is/vax your child ( ) Breast fed ( ) Both For how long?  What kind of idei is your child currently on?  Does your child have any suspected swallowing problems? ( ) Yes ( ) No  If yes, please specify  Has your child experienced recent weight gain? ( ) Yes ( ) No  Ones your child have any suspected swallowing problems? ( ) Yes ( ) No  Does your child have any suspected swallowing problems? ( ) Yes ( ) No  Does your child experienced recent weight gain? ( ) Yes ( ) No  Does your child require skilled nursing care in the home? ( ) Yes ( ) No  Does your child require skilled nursing care in the home? ( ) Yes ( ) No  Does your child require skilled nursing care in the home? ( ) Yes ( ) No | ( ) Cleft lip                                 | ( ) Cleft Palate  | ( ) Both   | left lip and cleft palate  |
| ( ) Contagious Diseases (Please include common childhood diseases) ( ) Asthan ( ) Other Respiratory problems: If yes, specify: ( ) Cerebrovascular accident (Stroke) ( ) Cerebral Palsy: If yes, Type: ( ) Cerebrovascular accident (Stroke) ( ) Cerebral Palsy: If yes, Type: ( ) Spina Biffid ( ) Autism/PDD ( ) Attention Deficit ( ) Cardiac (heart) problems: Specify: ( ) Pacemaker ( ) Delibrillator ( ) Palure to Thrive ( ) Gastrointestinal problems (ex: Reflux) Specify: ( ) Cancer: Specify: ( ) Diabetes ( ) Blood disorder ( ) Genetic Syndrome: If yes, specify: ( ) Orthopedic injuries (ex: broken bones) Specify: ( ) Orthopedic injuries (ex: broken bones) Specify: ( ) Joint Condition/Arthritis ( ) Torricollis ( ) Skin Condition ( ) Pregnant ( ) Lactating ( ) Other  Has your child ever experienced scizures? ( ) Yes ( ) No If yes, when was the last time? Is your child or medication for the seizures? ( ) Yes ( ) No If yes, what testing, and what were the results?  Sloumental History  At what age did your child: First roll over? Sit with assistance? Sit alone?  Craw? Pall to Stand?  Cruise furniture? Walk?  Hold items with two hands?  Reach to get what they want?  Babble? (ex: Baba, awaba, etc.)  Say first word? Use of variety of sounds in play?  Lyour child to ite trained? ( ) Yes ( ) No If yes, at what age: Please list your child: ( ) Breast fed ( ) Bothe fed ( ) Both For how long?  What kind of diet is your child currently on?  Does your child feed him/herself? ( ) Yes ( ) No Eat with assistance ( ) Yes ( ) No Does your child lave any suspected swallowing problems? ( ) Yes ( ) No Stevish fed by alternative feeding, methods? (G-tube, Ng tube) ( ) Yes ( ) No Does your child tequire skilled nursing care in the horne? ( ) Yes ( ) No Does your child require skilled nursing care in the horne? ( ) Yes ( ) No Does your child require skilled nursing care in the horne? ( ) Yes ( ) No  | ( ) Hydrocephaly                              | ( ) Microcephaly  | ( ) Macro  | ocephaly   |
| ( ) Asthma ( ) Sinus/Allergies: If yes, specify:   |   |   | ` ' ·  | . ,  |
| ( ) Other Respiratory problems: If yes, specify:   |   |   |  |  |
| ( ) Cerebrovascular accident (Stroke) ( ) Cerebral Palsy; If yes, Type: ( ) Spins Bifdid ( ) Autism/PDD ( ) Attention Deficit ( ) Cardiae (heart) problems: Specify: ( ) Pacemaker ( ) Defibrillator ( ) Failure to Thrive ( ) Gastrointestinal problems (ex: Reflux) Specify: ( ) Cancer: Specify: ( ) Diabetes ( ) Blood disorder ( ) Genetic Syndrome: If yes, specify: ( ) Orthopedic injuries (ex: broken bones) Specify: ( ) Joint Condition/Arthritis ( ) Torticollis ( ) Skin Condition ( ) Pregnant ( ) Lactaring ( ) Other  Has your child ever experienced seizures? ( ) Yes ( ) No If yes, when was the last time?  Is your child on medication for the seizures? ( ) Yes ( ) No If yes, when was the last time?  Is your child ever had special testing done for the seizures? ( ) Yes ( ) No If yes, what testing, and what were the rosults?  Stopmental History  At what age did your child: First roll over?  Sit alone?  Crawd? Pull to Stand?  Criving furniture? Walk?  Hold items with two hands? Pick things up?  Reach to get what they want?  Babble? (ex. Baba, awaba, etc.) Use of variety of sounds in play?  Say first word? Say first word? Use list your child is five trained? ( ) Yes ( ) No If yes, at what age: Pickes list your child is favorite toys  seeding/Swallowing  Js/was your child ( ) Breast fed ( ) Bottle fed ( ) Both For how long?  What kind of diet is your child currently on?  Does your child have any suspected swallowing problems? ( ) Yes ( ) No  Does your child have any suspected swallowing problems? ( ) Yes ( ) No  Is he/she fed by alternative (seding, methods? (G-tube, Ng tube) ( ) Yes ( ) No  Does your child experienced recent weight gain? ( ) Yes ( ) No OR weight loss? ( ) Yes ( ) No  Does your child texperienced recent weight gain? ( ) Yes ( ) No OR weight loss? ( ) Yes ( ) No  Does your child texperienced recent weight gain? ( ) Yes ( ) No OR weight loss? ( ) Yes ( ) No   | ` '   |   |  |  |
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| ( ) Failure to Thrive ( ) Gastrointestinal problems (ex: Reflux) Specify: ( ) Caneer: Specify: ( ) Diabetes ( ) Blood disorder ( ) Genetic Syndrome: If yes, specify: ( ) Orthopedic injuries (ex: broken bones) Specify: ( ) Joint Condition/Arthritis ( ) Torticolfis ( ) Skin Condition ( ) Pregnant ( ) Lactating ( ) Other.  Has your child ever experienced seizures? ( ) Yes ( ) No If yes, when was the last time?  Is your child on medication for the seizures? ( ) Yes ( ) No Has your child ever had special testing done for the seizures? ( ) Yes ( ) No If yes, what testing, and what were the results?  clopmental History  At what age did your child: Sit with assistance?  Crawl?  Pull to Stand?  Cruise furniture? Hold items with two hands?  Reach to get what they want?  Babble? (ex. Baba, awaba, etc.)  Say first word?  Is your child tollet trained? ( ) Yes ( ) No If yes, at what age:  Please list your child: ( ) Breast fed ( ) Both For how long?  What kind of diet is your child currently on?  Does your child feed him/hersel? ( ) Yes ( ) No Isat with assistance ( ) Yes ( ) No Does your child have any suspected swallowing problems? ( ) Yes ( ) No Is he/she fed by alternative feeding, methods? (G-tube, Ng tube) ( ) Yes ( ) No If yes, please specify  Has your child require skilled nursing care in the home? ( ) Yes ( ) No Does your child texperienced recent weight gain? ( ) Yes ( ) No Does your child require skilled nursing care in the home? ( ) Yes ( ) No  |   |   |  |  |
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| ( ) Genetic Syndrome: If yes, specify:   |   | ( ) Blood disord  | er   |  |
| ( ) Joint Condition/Arthritis ( ) Torticollis ( ) Skin Condition ( ) Pregnant ( ) Lactating ( ) Other  |   | cify:   |  |  |
| ( ) Pregnant ( ) Lactating ( ) Other  Has your child ever experienced seizures? ( ) Yes ( ) No If yes, when was the last time?  Is your child on medication for the seizures? ( ) Yes ( ) No Has your child ever had special testing done for the seizures? ( ) Yes ( ) No If yes, what testing, and what were the results?  clopmental History  At what age did your child: First roll over?  Sit alone?  Crawl? Pull to Stand?  Cruise furniture? Walk?  Hold items with two hands? Pick things up?  Reach to get what they want?  Babble? (ex. Baba, awaba, etc.) Use of variety of sounds in play?  Say first word? Combine words?  Is your child toitet trained? ( ) Yes ( ) No If yes, at what age:  Please list your child's favorite toys  seeding/Swallowing  Is/was your child ( ) Breast fed ( ) Bottle fed ( ) Both For how long?  What kind of diet is your child currently on?  Does your child have any suspected swallowing problems? ( ) Yes ( ) No  Does your child have any suspected swallowing problems? ( ) Yes ( ) No  Is he/she fed by alternative feeding, methods? (G-tube, Ng tube) ( ) Yes ( ) No  Has your child experienced recent weight gain? ( ) Yes ( ) No  Ones your child require skilled nursing care in the home? ( ) Yes ( ) No  Does your child require skilled nursing care in the home? ( ) Yes ( ) No   |   |   |  |  |
| Has your child ever experienced seizures? ( ) Yes ( ) No If yes, when was the last time?  Is your child on medication for the seizures? ( ) Yes ( ) No Has your child ever had special testing done for the seizures? ( ) Yes ( ) No If yes, what testing, and what were the results?  slopmental History  At what age did your child: First roll over?  Sit with assistance? Sit alone?  Crawl? Pull to Stand?  Cruise furniture? Walk?  Hold items with two hands? Pick things up?  Reach to get what they want?  Babble? (ex. Baba, awaba, etc.) Use of variety of sounds in play?  Say first word? Combine words?  Is your child toilet trained? ( ) Yes ( ) No If yes, at what age: Please list your child's favorite toys  seeding/Swallowing  Is/was your child: ( ) Breast fed ( ) Bottle fed ( ) Both For how long?  What kind of diet is your child currently on?  Does your child have any suspected swallowing problems? ( ) Yes ( ) No Does your child have any suspected swallowing problems? ( ) Yes ( ) No Is he/she fed by alternative feeding, methods? (G-tube, Ng tube) ( ) Yes ( ) No If yes, please specify  Has your child experienced recent weight gain? ( ) Yes ( ) No OR weight loss? ( ) Yes ( ) No Does your child require skilled nursing care in the home? ( ) Yes ( ) No   |   | ( ) Torticollis   | ( ) Skin Condition   | WITH WITH A COLUMN TO THE COLU |
| It is your child ever experienced seizures? ( ) Yes ( ) No If yes, when was the last time?  It your child on medication for the seizures? ( ) Yes ( ) No  Has your child ever had special testing done for the seizures? ( ) Yes ( ) No  If yes, what testing, and what were the results?  **Elopmental History**  At what age did your child: First roll over?  Sit with assistance? Sit alone?  Crawl? Pull to Stand?  Cruise furniture? Walk?  Hold items with two hands? Pick things up?  Reach to get what they want?  Babble? (ex. Baba, awaba, etc.) Use of variety of sounds in play?  Say first word? Combine words?  Is your child toilet trained? ( ) Yes ( ) No If yes, at what age:  Please list your child's favorite toys  **eeding/Swallowing**  Does your child feed him/herself? ( ) Yes ( ) No  Eat with assistance ( ) Yes ( ) No  Does your child have any suspected swallowing problems? ( ) Yes ( ) No  Is he/she fed by alternative feeding, methods? (G-tube, Ng tube) ( ) Yes ( ) No  If yes, please specify  Has your child experienced recent weight gain? ( ) Yes ( ) No  Does your child require skilled nursing care in the home? ( ) Yes ( ) No  Does your child require skilled nursing care in the home? ( ) Yes ( ) No  | . , 2   |   |  |  |
| Is your child on medication for the seizures? ( ) Yes ( ) No Has your child ever had special testing done for the seizures? ( ) Yes ( ) No If yes, what testing, and what were the results?  clopmental History  At what age did your child: First roll over?  Sit with assistance? Sit alone?  Crawl? Pull to Stand?  Cruise furniture? Walk?  Hold items with two hands? Pick things up?  Reach to get what they want?  Babble? (ex. Baba, awaba, etc.) Use of variety of sounds in play?  Is your child toilet trained? ( ) Yes ( ) No If yes, at what age:  Please list your child's favorite toys  ceding/Swallowing  Is/was your child: ( ) Breast fed ( ) Bottle fed ( ) Both For how long?  What kind of diet is your child currently on?  Does your child feed him/herself? ( ) Yes ( ) No  Does your child have any suspected swallowing problems? ( ) Yes ( ) No  Use of variety of sounds in play?  Does your child have any suspected swallowing problems? ( ) Yes ( ) No  Is he/she fed by alternative feeding, methods? (G-tube, Ng tube) ( ) Yes ( ) No  If yes, please specify  Has your child experienced recent weight gain? ( ) Yes ( ) No  Oocs your child require skilled nursing care in the home? ( ) Yes ( ) No   |   |   |  |  |
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| At what age did your child:  Sit with assistance?  Crawf?  Cruise furniture?  Hold items with two hands?  Reach to get what they want?  Babble? (ex. Baba, awaba, etc.)  Say first word?  Lyse of variety of sounds in play?  Say first word?  Is your child toilet trained? ( ) Yes ( ) No If yes, at what age:  Please list your child's favorite toys  seeding/Swallowing  Is/was your child. ( ) Breast fed ( ) Bottle fed ( ) Both  For how long?  What kind of diet is your child currently on?  Does your child feed him/herself? ( ) Yes ( ) No  Does your child have any suspected swallowing problems? ( ) Yes ( ) No  Is he/she fed by alternative feeding, methods? (G-tube, Ng tube) ( ) Yes ( ) No  If yes, please specify  Has your child experienced recent weight gain? ( ) Yes ( ) No  ON OR weight loss? ( ) Yes ( ) No  Does your child require skilled oursing care in the home? ( ) Yes ( ) No   | , ,   | the results?  | Pro  |  |
| Sit with assistance?  Crawl?  Cruise furniture?  Hold items with two hands?  Reach to get what they want?  Babble? (ex. Baba, awaba, etc.)  Say first word?  Is your child toilet trained? () Yes () No If yes, at what age:  Please list your child's favorite toys  reding/Swallowing  Is/was your child. () Breast fed () Bottle fed () Both For how long?  What kind of diet is your child currently on?  Does your child feed him/herself? () Yes () No  Does your child have any suspected swallowing problems? () Yes () No  Does your child have any known swallowing problems? () Yes () No  Is he/she fed by alternative feeding, methods? (G-tube, Ng tube) () Yes () No  If yes, please specify  Has your child require skilled nursing care in the home? () Yes () No  Does your child require skilled nursing care in the home? () Yes () No   | velopmental History                           |   |  |  |
| Cruise furniture?  | At what age did your child:                   |   |  |  |
| Cruise furniture?  | Sit with assistance?                          | Visionia reserva visionia a reserva visionia di P   | Sit alone?   | HAMA-Aurola Antonomica Antonomica Antonomica Antonomica Antonomica Antonomica Antonomica Antonomica Antonomica   |
| Hold items with two hands?   | Crawl?  |   | Pull to Stand?   |  |
| Reach to get what they want?  Babble? (ex. Baba, awaba, etc.)  Say first word?  Is your child toilet trained? ( ) Yes ( ) No If yes, at what age:  Please list your child's favorite toys  ceding/Swallowing  Is/was your child: ( ) Breast fed ( ) Bottle fed ( ) Both For how long?  What kind of diet is your child currently on?  Does your child feed him/herself? ( ) Yes ( ) No Eat with assistance ( ) Yes ( ) No  Does your child have any suspected swallowing problems? ( ) Yes ( ) No  Is he/she fed by alternative feeding, methods? (G-tube, Ng tube) ( ) Yes ( ) No  If yes, please specify  Has your child experienced recent weight gain? ( ) Yes ( ) No OR weight loss? ( ) Yes ( ) No  Does your child require skilled nursing care in the home? ( ) Yes ( ) No   | Cruise furniture?                             |   | Walk?  |  |
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| Babble? (ex. Baba, awaba, etc.)  Say first word?  Is your child toilet trained? ( ) Yes ( ) No If yes, at what age:  Please list your child's favorite toys  reding/Swallowing  Is/was your child: ( ) Breast fed ( ) Bottle fed ( ) Both For how long?  What kind of diet is your child currently on?  Does your child feed him/herself? ( ) Yes ( ) No Eat with assistance ( ) Yes ( ) No  Does your child have any suspected swallowing problems? ( ) Yes ( ) No  Does your child have any known swallowing problems? ( ) Yes ( ) No  Is he/she fed by alternative feeding, methods? (G-tube, Ng tube) ( ) Yes ( ) No  If yes, please specify  Has your child experienced recent weight gain? ( ) Yes ( ) No OR weight loss? ( ) Yes ( ) No  Does your child require skilled nursing care in the home? ( ) Yes ( ) No   |   |   |  |  |
| Say first word? Combine words?  Is your child toilet trained? ( ) Yes ( ) No If yes, at what age:  Please list your child's favorite toys  ceding/Swallowing  Is/was your child: ( ) Breast fed ( ) Bottle fed ( ) Both For how long?  What kind of diet is your child currently on?  Does your child feed him/herself? ( ) Yes ( ) No   |   |   | Use of variety of sounds in pl   | ay?  |
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| Does your child feed him/herself? ( ) Yes ( ) No  Eat with assistance ( ) Yes ( ) No  Does your child have any suspected swallowing problems? ( ) Yes ( ) No  Does your child have any known swallowing problems? ( ) Yes ( ) No  Is he/she fed by alternative feeding, methods? (G-tube, Ng tube) ( ) Yes ( ) No  If yes, please specify  Has your child experienced recent weight gain? ( ) Yes ( ) No  Does your child require skilled nursing care in the home? ( ) Yes ( ) No   |   |   |  |  |
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| Has your child experienced recent weight gain? ( ) Yes ( ) No OR weight loss? ( ) Yes ( ) No Does your child require skilled nursing care in the home? ( ) Yes ( ) No  | If yes, please specify                        |   | Andrew Assessment Control of the Con |  |
| Does your child require skilled nursing care in the home? ( ) Yes ( ) No   |   |   |  |  |
|  | Does your child require skilled nursing care  | n the home? ( ) Y   | es ( ) No  |  |
|  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,       | . ,   |  | A NATURIANA NUNI USIAN DANKAU SANI NS AVERS  |

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|          | Does your child have any vision problems? ( ) Yes ( ) No   |
|----------|--|
|          | If yes, please clarify:  |
|          | History  |
|          | Do you have any concerns about your child's hearing? ( ) Yes ( ) No  |
|          | If yes, please explain:  |
|          | Is there a family history of hearing loss? ( ) Yes ( ) No  |
|          | If yes, please explain:  |
|          | Does your child have a history of acute or chronic otitis media (car infections)? ( ) Yes ( ) No                   |
|          | If yes, has your child ever had "tubes"? ( ) Yes ( ) No  |
|          | If yes, how old was your child when they were placed?  |
|          | Has your child's hearing been screened or tested before? ( ) Yes ( ) No  |
|          | If yes, when was the testing completed and what were the results?  |
|          | If treatment or follow-up was recommended, please describe:  |
| Commu    | nication Needs   |
|          | Do you or your child have any special communication needs?   |
|          | Child:   |
|          | Caregiver:   |
|          | What is your preferred language?  Child: Caregiver:  |
| .earnin  | g Profile  |
|          | Do you or your child have any barriers to learning? (ex. Visual, hearing, language, or mental impairments?)        |
|          | Child:   |
|          | Caregiver:   |
|          | How do you feel your child learns best? ( ) visualization ( ) verbal instruction ( ) demonstration                 |
|          | How does caregiver learn best? ( ) visualization ( ) verbal instruction ( ) demonstration                          |
| oes yo   | ur child attend school or daycare? If so, what type and are there any special services provided?                   |
| oes the  | e child or caregiver have any limitations in mobility (ex. Use a wheelchair, crutches, or have difficulty moving?) |
|          | Child:   |
|          | Caregiver:   |
| Family ( | Goal for Evaluation/Treatment:   |
| Person ( | completing Form: Relationship to Child:  |
| Signed:  | Date:  |
|          |  |
| Informa  | ntion reviewed and verified by clinician   |
|          |  |
|          | Patient  |
|          | Label  |

THITK



## PEDIATRIC THERAPY MEDICATIONS AND ALLERGIES

| tient's Name:                           |                               | Date of Birth:                             | Age:  |   |
|---|-------------------------------|--|---|---|
| rrent Medications:                      |                               |  |   |   |
| Medication Name                         | Dose                          | Route (by mouth, etc)                      | How often   | Reaso   |
| 27 - 17 - 17 - 17 - 17 - 17 - 17 - 17 - |                               | No. 44 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 |   |   |
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|   |                               |  |   | · · · · · · · · · · · · · · · · · · ·                       |
|   |                               |  |   |   |
| your child have any allerg<br>Allergy   |                               | 0  | rity (mild, moderate, critical, u   | ınknown)  |
| Allergy                                 | ies? ()yes ()n<br>Reactio     | o<br>on Sever                              | rity (mild, moderate, critical, u<br>mild ( ) moderate ( ) critical   | ( ) unknown   |
| Allergy                                 | ies? ( ) yes ( ) n<br>Reactio | o<br>on Sever<br>( )                       | rity (mild, moderate, critical, u<br>mild ( ) moderate ( ) critical<br>mild ( ) moderate ( ) critical   | ( ) unknown<br>( ) unknown                                  |
| Allergy                                 | ies? ()yes ()n<br>Reactio     | on Sever                                   | rity (mild, moderate, critical, u<br>mild ( ) moderate ( ) critical<br>mild ( ) moderate ( ) critical<br>mild ( ) moderate ( ) critical   | ( ) unknown<br>( ) unknown<br>( ) unknown                   |
| Allergy                                 | ies? ()yes ()n<br>Reactio     | o Sever                                    | rity (mild, moderate, critical, u<br>mild ( ) moderate ( ) critical<br>mild ( ) moderate ( ) critical<br>mild ( ) moderate ( ) critical<br>mild ( ) moderate ( ) critical                                   | ( ) unknown ( ) unknown ( ) unknown ( ) unknown             |
| Allergy                                 | ies? ()yes ()n<br>Reactio     | o Sever                                    | rity (mild, moderate, critical, u<br>mild ( ) moderate ( ) critical<br>mild ( ) moderate ( ) critical<br>mild ( ) moderate ( ) critical   | ( ) unknown ( ) unknown ( ) unknown ( ) unknown             |
| Allergy                                 | ies? ()yes ()n<br>Reactio     | o Sever ( ) ( ) ( ) ( ) ( )                | rity (mild, moderate, critical, u<br>mild ( ) moderate ( ) critical<br>mild ( ) moderate ( ) critical<br>mild ( ) moderate ( ) critical<br>mild ( ) moderate ( ) critical                                   | ( ) unknown |
|   | ies? ()yes ()n<br>Reactio     | o Sever ( ) ( ) ( ) ( ) ( )                | rity (mild, moderate, critical, u<br>mild ( ) moderate ( ) critical<br>mild ( ) moderate ( ) critical | ( ) unknown |

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