Pediatric Therapy Patient Paperwork

If you are a new patient or have not completed a case history in the last six months, please complete this paperwork, print it and bring it with you to your appointment.

Women & Children
HUNTSVILLE HOSPITAL

PEDIATRIC THERAPY & AUDIOLOGY
CASE HISTORY FORM

Women & Children
HUNTSVILLE HOSPITAL

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

Preferred Name or Nickname: _____ **( ) Male ( ) Female**

Referring Physician: _____ **Services Requested: ( ) PT ( ) OT ( ) ST ( ) Audiology**

Diagnosis _____

Is your child currently receiving therapy services? ( ) Yes ( ) No What Type? ( ) PT ( ) OT ( ) ST

If 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):_____

Medical 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 or 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:

Date	**Reason for Hospitalization**	**Surgery**

Patient Label

THITK

Has your child ever been diagnosed with any of the following conditions?

( ) Cleft lip ( ) Cleft Palate ( ) Both cleft lip and cleft palate
( ) Hydrocephaly ( ) Microcephaly ( ) Macrocephaly
( ) Encephalitis ( ) Meningitis ( ) Cytomegalovirus (CMV)
( ) Contagious Diseases (Please include common childhood diseases) _____
( ) Asthma ( ) Sinus/Allergies: If yes, specify: _____
( ) Other Respiratory problems: If yes, specify: _____
( ) Cerebrovascular accident (Stroke) ( ) Cerebral Palsy: If yes, Type: _____
( ) Spina Bifida ( ) Autism/PDD_____ ( )Attention Deficit
( ) Cardiac (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 ( ) 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? _____

Developmental 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 _____

Feeding/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

Patient Label

THITK

Does your child have any vision problems? ( ) Yes ( ) No

If yes, please clarify: _____

Hearing 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 (ear 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: _____

_____

Communication Needs

Do you or your child have any special communication needs?

Child: _____

Caregiver: _____

What is your preferred language?

Child: _____ Caregiver: _____

Learning 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

Does your child attend school or daycare? If so, what type and are there any special services provided?

_____

Does the 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: _____

Information reviewed and verified by clinician_____

Clinician signature/date/time

Patient Label

THITK

PEDIATRIC THERAPY
MEDICATIONS AND ALLERGIES

Women & Children
HUNTSVILLE HOSPITAL

Patient's Name: _____ **Date of Birth:** _____ **Age:** _____

Current Medications:

Medication Name	Dose	Route (by mouth, etc)	How often	Reason

Does your child have any allergies? ( ) **yes** ( ) **no**

Allergy	Reaction	Severity (mild, moderate, critical, unknown)
		( ) mild ( ) moderate ( ) critical ( ) unknown
		( ) mild ( ) moderate ( ) critical ( ) unknown
		( ) mild ( ) moderate ( ) critical ( ) unknown
		( ) mild ( ) moderate ( ) critical ( ) unknown
		( ) mild ( ) moderate ( ) critical ( ) unknown

Person completing Form: _____ **Relationship to Patient:** _____

Signed: _____ **Date:** _____

Information reviewed and verified by clinician: _____
Clinician signature/date/time

Patient Label

THMED

PEDIATRIC THERAPY POLICIES
(256) 265-7952 phone
(256) 265-7953 fax

THITK

Women & Children
HUNTSVILLE HOSPITAL

Supervision: 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.

Siblings: While siblings may be helpful during therapy sessions, they also 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 the sibling needs to wait in the lobby. Please plan to have your other children supervised.

Participation: Parents/caregivers are expected to actively participate in therapy sessions with their child. This optimizes carryover 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.

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.

Cancellations: 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.

Tardiness: It is very important for your child to arrive on time for their 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 rescheduled.

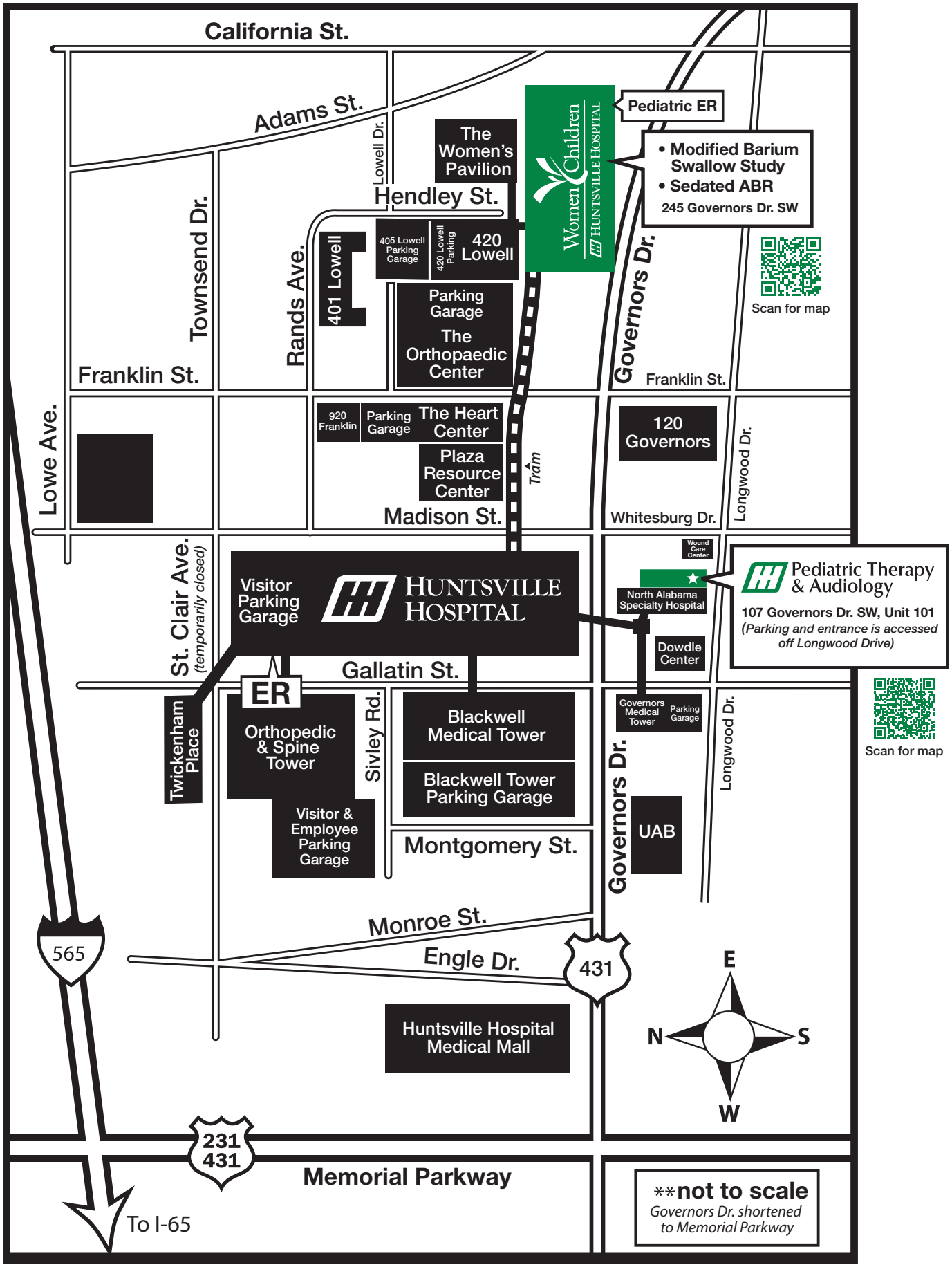
No Shows: Should you fail to show for a scheduled appointment, a "no show" be documented in your child's chart. After ***two consecutive or three total*** **"no shows," your child will be discharged from therapy.** A letter will be sent to your child's physician to notify them. If, in the future, you 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.

Inclement Weather: 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.

Insurance Coverage: 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.**

I have read and understand the above policies.

_____ _____ _____

Patient's Representative **Date** **Time**

HUNTSVILLE HOSPITAL / Medical District