The Children's TherAplay Foundation, Inc.

New Patient Intake Form – ALL FIELDS REQUIRED

Date:____________________ How did you hear about Children's TherAplay? ____________________________________

Referral for: □ Physical Therapy □ Occupational Therapy □ Speech Therapy

Patient Name: ___________________________________DOB: ___________Ethnicity/Race:______________ □Prefer not to answer

Diagnosis: ____ Weight: _________ Height: _____________

Can patient sit independently? □Yes □No Walk independently? □Yes □No Verbal? □Yes □No

How much assistance is required for transfers? □ Min (25% help) □ Mod (50% help) □ Max (75% help) □ Total Assist (100% help)

How long can your child hold their head up while in a seated position? ____

Does your child have any of the following health conditions?:

Atlanto-axial instability with neurological signs as assessed by MD	□Yes □No	Mental health conditions that place the patient or others at significant safety risk (e.g., severely aggressive behaviors, frequent hitting, biting, throwing, scratching, screaming, or elopement)	□Yes □No
Chiari malformation with neurological symptoms	□Yes □No	Coxa Arthrosis	□Yes □No
Seizures or unstable neurological system uncontrolled by medication	□Yes □No	Hemophilia with recent history of bleeding episodes	□Yes □No
Indwelling urethral catheters	□Yes □No	Medical conditions during acute exacerbations (e.g., asthma flare ups, seizures, etc.)	□Yes □No
Open wounds over a weightbearing surface	□Yes □No	Pathological fractures without successful treatment of the underlying pathology	□Yes □No
Acute fractures	□Yes □No	Tethered cord syndrome with symptoms	□Yes □No
Unstable spine and/or internal hardware of fixation/fusion	□Yes □No	Difficulties with being touched/handled during transfers or daily activities	□Yes □No

What therapies does patient currently receive?_________________________Location:______________________

Date of last PT/OT/ST evaluation:_____________________Location: ____________________________________

Preferred Times for therapy appointments: (please check **ALL** options) ☐AM ☐PM

□ Monday □ Tuesday □ Wednesday □ Thursday □ Friday □ Float (learn more on back)

Family Goals for Patient:

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____

Parent/Guardians:____

Address:____

City, State, Zip: ____

Home Phone:________________________Cell:______________________E-mail: ___________________________

Referring Physician: ____

Physician's Medical Group: ____

Physician's Address: ____

MD Phone: ______________________ MD Fax: ______________________

Referring Therapist: ______________________ Phone: ______________________

Insurance: Please check ALL that apply

□ Medicaid □ Children's Special Health Care Services □ Self-Pay □ Private Insurance

Medicaid Case Manager: ______________ Phone: ______________ Fax: ______________

Type of MCD: □ Traditional □ Waiver □ Risk Based Managed Care

Client's RID #: ______________________ Effective Date: ______________

CSHCS: ID #: ______________________ Effective Date: ______________

Private Insurance:

Company: ____

Insured's Name: ______________________ DOB: ______________________

Policy# ______________________ Group # ______________________

Provider Services Phone Number (on back of card) ______________________

Communication Permissions

Appointment reminders and treatment follow-up messages may be sent via cell phone SMS texting. It is your right to decline communication of this nature for any reason.

I would like to opt out of texts

Please be sure to inform us of ANY changes in your insurance. Failure to do so may result in patient responsibility for the entire billable amount.

Please return this form to Kaylin Shiver at kshiver@childrenstheraplay.org.

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What does a "float" schedule mean?

It can often be hard to some families to schedule and keep weekly reoccurring appointments. We realize that families have a lot going on. "Float scheduling" provides families the flexibility they may need. It allows the family to tell Children's TherAplay (CTF) what time works for them each week. This may change as often as the family needs it to and is scheduled by the parent one week prior to the next appointment. These appointments can be made by phone or at the check-out desk following each appointment.