The Children's TherAplay Foundation, Inc.
New Patient Intake Form – ALL FIELDS REQUIRED

Date: ________________ How did you hear about Children's TherAplay? ___________________________________

Referral for (please check): ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

Patient Name: ____ DOB: _________________________________

Diagnosis: ____ Weight: ___________ Height: ________

Preferred Language: ____ Sex: ☐ Male ☐ Female

Can child sit independently? ☐ Yes ☐ No Walk independently? ☐ Yes ☐ No Verbal? ☐ Yes ☐ No

How much assistance/help is required for transfers? ☐ None ☐ 25% ☐ 50% ☐ 75% ☐ 100%

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

Does your child have a severe aversion/fear of animals (dogs/horses)? ☐ Yes ☐ No ☐ Not sure

Does your child have any of the following health conditions?

Condition		Condition	
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

Preferred Times for therapy appointments: (please check **ALL** options that apply)

	8am	9am	10am	11am	1pm	2pm	3pm	4pm	5pm
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									

*****FLOAT: ☐ Yes ☐ No** **What does a "float" schedule mean?**

It can often be hard for some families to schedule weekly reoccurring appointments. We realize that families have differing scheduling needs. "**Float scheduling**" provides families the flexibility they may need, as it allows the family to choose dates/times for appointments on a week-to-week basis. Furthermore, "**floating**" allows your child to attend appointments while they wait for a permanent weekly time appointment that accommodates your schedule the best. Appointments can be made by phone, text, or at the front office on a week-to-week basis.

Family Goals for Patient:

Caregivers/Guardian Address: ____
City: ______________________________ **State:** __________ **Zip:** ______________
Guardian 1 Phone: ____________________ **Guardian 2 Phone:** ____________________
Guardian 1 Email: ____________________**Guardian 2 Email:** ____________________

Referring Physician Name: ____
Physician's Medical Group: ____
Physician's Address: ______________________ **City:** __________ **State:** _____ **Zip:** ______
MD Phone: ______________________ **MD Fax:** ____________________________

Therapies patient currently receives: ☐ PT ☐ OT ☐ ST ☐ None
Location(s): ____

Insurance: Please check **ALL** that apply

☐ Medicaid ☐ Children's Special Health Care Services ☐ Self-Pay ☐ Private Insurance
☐ CareSource **(NOT IN NETWORK)**

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

Client's RID #: ______________________**Effective Date:** ____________________

Childrens Special Health Care Services (CSHCS):
ID #: ______________________________ **Effective Date:** ____________________

Private Insurance:
Private Insurance Company: ____
Insurance Company Address: ____
City: ______________________ **State:** __________ **Zip:** ____________________
Insured's Name: ______________________________ **DOB:** ______________
Relationship to Client: ____
Policy/Group #: ______________________ **ID #:** ______________________
Member/Provider services phone number listed on back of card: ______________________

In Network Insurance Plans: Anthem, United Health Care, Cigna, Medicaid, Medicaid Entities. Out of network plans may have out of network benefits. Individual plans will vary, contact Brenda Adamson at badamson@childrenstheraplay.org to verify your insurance.

Every family/patient must provide **ALL** current insurances. Any and all insurance changes must be provided. Failure to do so will result in patient responsibility for the entire billable amount.

Email this form to Karina Carter at kcarter@childrenstheraplay.org