



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: _____ Sex: ☐ M ☐ F DOB: _____ Ethnicity/Race: _____

Diagnosis: _____ Weight: _____ Height: _____

Preferred Language: _____

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

How much assistance is required for transfers? ☐ No Help ☐ 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	<input type="checkbox"/> Yes <input type="checkbox"/> 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chiari malformation with neurological symptoms	<input type="checkbox"/> Yes <input type="checkbox"/> No	Coxa Arthrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures or unstable neurological system uncontrolled by medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia with recent history of bleeding episodes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Indwelling urethral catheters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medical conditions during acute exacerbations (e.g., asthma flare ups, seizures, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Open wounds over a weightbearing surface	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pathological fractures without successful treatment of the underlying pathology	<input type="checkbox"/> Yes <input type="checkbox"/> No
Acute fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tethered cord syndrome with symptoms	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unstable spine and/or internal hardware of fixation/fusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulties with being touched/handled during transfers or daily activities	<input type="checkbox"/> Yes <input type="checkbox"/> 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 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.

Family Goals for Patient: _____

Parent/Guardians: _____

Address: _____

City, State, Zip: _____

Preferred Phone: _____ Cell: _____ E-mail: _____

Referring Physician: _____

Physician's Medical Group: _____

Physician's Address: _____

MD Phone: _____ MD Fax: _____

What therapies does patient currently receive? _____ Location: _____

Date of last PT/OT/ST evaluation: _____ Location: _____

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) _____

Please be sure to provide ALL current insurances. Any and all insurance changes must be provided, 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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