The Children's TherAplay Foundation, Inc.

New Patient Intake Form – ALL FIELDS REQUIRED

Date: _____ **How did you hear about Children's TherAplay?** _____

Name of Person Completing this Form: _____ **Relationship:** _____

Services Requested: ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

Patient Name: _____

DOB: _____ [Note: Age Policy-Child must be 18 months-12 years 11 months old and 2 years old if patient with diagnosis of Down Syndrome)

Diagnosis: _____

Weight: _____ [Note: Weight Policy- If child requires maximum assistance is ≤40 lbs; if child requires less assistance up to 80–100 lbs.]

Height: _____

Sex Assigned at Birth: ☐ Male ☐ Female

Preferred Language: _____

Can your child sit independently? ☐ Yes ☐ No

Can your child walk independently? ☐ Yes ☐ No

Is your child 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 severe *aversions/fears* of animals (dogs/horses)? ☐ Yes ☐ No ☐ Not sure

Does your child have a *severe allergy* to dogs/horses/hay? ☐ Yes ☐ No ☐ Not sure

Patient Name: _____ **DOB**: _____

Does your child have any of the following health conditions?

Failure to report medical conditions may place your child at risk of injury. Please email us if you need assistance completing the following medical information:

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 (i.e., headaches, neck pain, balance problems, muscle weakness, numbness or tingling, visual disturbances, swallowing problems, hearing loss and tinnitus, dizziness and vertigo, sleep apnea, psychological concerns such as insomnia or depression)	☐ Yes ☐ No	Coxa Arthrosis (a chronic disease that causes cartilage in the hip joint to gradually deteriorate)	☐ Yes ☐ No
Seizures or unstable neurological system uncontrolled (i.e., break through seizures) 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 or without symptoms (i.e., pain in lower back, shooting leg paid, rectal and/or genital pain, weakness or numbness in legs/feet, difficulty standing or walking or an abnormal walking pattern, loss of bladder or bowel control, urinary frequency, or constipation, or worsening of scoliosis)	☐ Yes ☐ No
Unstable spine or joints and/or including unstable internal hardware	☐ 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)

Monday	8am ☐	9am ☐	10am ☐	11am ☐	12pm ☐		2:30pm ☐	3:30pm ☐	4:30pm ☐	5:30pm ☐
Tuesday	8am ☐	9am ☐	10am ☐	11am ☐		1:30pm ☐	2:30pm ☐	3:30pm ☐	4:30pm ☐	
Wednesday	8am ☐	9am ☐	10am ☐	11am ☐	12pm ☐		2:30pm ☐	3:30pm ☐	4:30pm ☐	5:30pm ☐
Thursday	8am ☐	9am ☐	10am ☐	11am ☐		1:30pm ☐	2:30pm ☐	3:30pm ☐		
Friday	8am ☐	9am ☐	10am ☐	11am ☐		1:00pm ☐	2:00pm ☐	3:00pm ☐	4:00pm ☐	

Family Goals for Patient (write a couple sentences about your primary concerns/goals for therapy):

Patient Name: _____ **DOB:** _____

Caregivers/Guardian Address: _____

City: _____ **State:** _____ **Zip:** _____

Guardian 1 Phone: _____ **Guardian 2 Phone:** _____

Guardian 1 Email: _____ **Guardian 2 Email:** _____

Referring Physician Name (the physician who will be signing the referral for services and treatment notes):

_____

Physician's Medical Group Name: _____

Physician's Address: _____

City: _____ **State:** _____ **Zip:** _____

MD Phone: _____ **MD Fax:** _____

Therapies patient currently receives: ☐ PT ☐ OT ☐ ST ☐ None *(MUST COMPLETE-May impact insurance coverage)*
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:** _____

Children's 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 (except Caresource). Out of network plans may have out of network benefits. Individual plans will vary, contact our billing department at billing@childrenstheraplay.org with any insurance questions.

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

Email this form to intake@childrenstheraplay.org