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	□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	Severe 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 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(s):_____
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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