



# 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  
 CareSource (NOT IN NETWORK)

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) \_\_\_\_\_

**In Network Insurance: Anthem, Uniter Health Care, Cigna, Medicaid, Medicaid Entities.** Out of network plans may have out of network benefits. Individual plan will vary, contact Brenda Adamson at [badamson@childrenstheraplay.org](mailto:badamson@childrenstheraplay.org) to verify your insurance.

**Please be sure to 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.**

**Turn this form to Kaylin Shiver at [kshiver@childrenstheraplay.org](mailto:kshiver@childrenstheraplay.org)**

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