



# 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: \_\_\_\_\_

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?

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)

<b>Monday</b>	8am <input type="checkbox"/>	9am <input type="checkbox"/>	10am <input type="checkbox"/>	11am <input type="checkbox"/>	12pm <input type="checkbox"/>	1:30pm <input type="checkbox"/>	2:30pm <input type="checkbox"/>	3:30pm <input type="checkbox"/>	4:30pm <input type="checkbox"/>	5:30pm <input type="checkbox"/>
<b>Tuesday</b>	8am <input type="checkbox"/>	9am <input type="checkbox"/>	10am <input type="checkbox"/>	11am <input type="checkbox"/>		1:30pm <input type="checkbox"/>	2:30pm <input type="checkbox"/>	3:30pm <input type="checkbox"/>	4:30pm <input type="checkbox"/>	
<b>Wednesday</b>	8am <input type="checkbox"/>	9am <input type="checkbox"/>	10am <input type="checkbox"/>	11am <input type="checkbox"/>	12pm <input type="checkbox"/>		2:30pm <input type="checkbox"/>	3:30pm <input type="checkbox"/>	4:30pm <input type="checkbox"/>	5:30pm <input type="checkbox"/>
<b>Thursday</b>	8am <input type="checkbox"/>	9am <input type="checkbox"/>	10am <input type="checkbox"/>	11am <input type="checkbox"/>		1:30pm <input type="checkbox"/>	2:30pm <input type="checkbox"/>	3:30pm <input type="checkbox"/>		
<b>Friday</b>	8am <input type="checkbox"/>	9am <input type="checkbox"/>	10am <input type="checkbox"/>	11am <input type="checkbox"/>		1:00pm <input type="checkbox"/>	2:00pm <input type="checkbox"/>	3:00pm <input type="checkbox"/>	4:00pm <input type="checkbox"/>	

**\*\*\*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. Appointments can be made by phone, text, or at the front office.

**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 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: \_\_\_\_\_

**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](mailto:badamson@childrenstheraplay.org) to verify your insurance.

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 Karina Carter at [kcarter@childrenstheraplay.org](mailto:kcarter@childrenstheraplay.org)**