5-Hole 1/4 1 3/8 c-to-c

PATIENT INFORMATION

Patient Name: _____ Sex: ☐ Male ☐ Female
Last First Middle

Nickname: _____ Child's Social Security (SS) #: _____ Date of Birth: _____

Parent/Legal Guardian: _____ Relationship: _____ SS#: _____

Parent/Legal Guardian: _____ Relationship: _____ SS#: _____

Address: _____
Street City State Zip

E-mail Address: _____ Religion: _____

Referred By: _____ Address: _____ Phone #: _____

Physician: _____ Phone #: _____

Physician Address: _____ Fax #: _____

*Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White
☐ Hispanic or Latino ☐ Native Hawaiian / Other Pacific Islander ☐ Other

*Ethnicity Hispanic/Latino or Alaska Native ☐ Yes ☐ No Language(s) Spoken in the Home: _____

Are there any religious/cultural practices we should know about that could better help us take care of your child: ☐ Yes ☐ No

If "Yes", please explain: _____

Please list names and ages of people living in your home with the child:

Name	Age	Name	Age	Name	Age

ALLERGIES

Food / Environmental Allergies? ☐ No ☐ Yes If Yes, please enter here or attach list:

_____

_____

_____

Medication Allergies? ☐ No ☐ Yes If Yes, please enter here or attach list:

_____

_____

_____

MEDICATION PROFILE *(Attach list if necessary)*

Medication Name	Dose	Frequency

I understand that it is my responsibility to provide updated information to Our Children's House at Baylor (OCH) on any changes in my child's medications and/or allergies. If I fail to provide this information in a timely manner, I hereby release Our Children's House at Baylor from all liability on information that has become inaccurate.

_____ _____
****Parent/Guardian Signature** **Date**

Therapist Initials: _____ _____ _____ _____ _____ _____

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PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

I. HOW TO CONTACT:

I wish to be contacted in the following manner:

Primary Phone #: _____ Relationship to Child: _____

(please check one): ☐ Home ☐ Cell ☐ Work ☐ Other: _____

Messages: ☐ OK to leave message with detailed information ☐ Leave a message with call-back number only

Secondary Phone #: _____ Relationship to Child: _____

(please check one): ☐ Home ☐ Cell ☐ Work ☐ Other: _____

Messages: ☐ OK to leave message with detailed information ☐ Leave a message with call-back number only

Alternate 1 Phone #: _____ Relationship to Child: _____

(please check one): ☐ Home ☐ Cell ☐ Work ☐ Other: _____

Messages: ☐ OK to leave message with detailed information ☐ Leave a message with call-back number only

Alternate 2 Phone #: _____ Relationship to Child: _____

(please check one): ☐ Home ☐ Cell ☐ Work ☐ Other: _____

Messages: ☐ OK to leave message with detailed information ☐ Leave a message with call-back number only

Written Communication:

☐ Mail to address: _____

Address *City* *State* *Zip*

☐ Fax to this number: _____

☐ E-mail to: _____

II. WHOM TO CONTACT: ☐ **I do not wish Our Children's House at Baylor to disclose/discuss information to/with anyone.**

I hereby give permission for Our Children's House at Baylor (OCH) to disclose/discuss any information related to my child's therapy session(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name	Relationship	Name	Relationship

III. WHOM TO RELEASE CHILD TO: **Same as listed above:** ☐ **Yes** ☐ **No**

Your child will not be released to any person(s) whose name does not appear on this form. **NO verbal authorizations will be permitted.** Any additions or deletions MUST be submitted in writing. OCH Staff reserve the right to ask any individual to show proper identification. This is for the protection of your child.

I hereby give permission to Our Children's House at Baylor to release my child in my absence to any of the following people:

Name	Relationship	Name	Relationship

The duration of this authorization is infinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of any medical information.

_____ _____

****Parent/Guardian Signature** **Date**

Therapist Initials: _____ _____ _____ _____ _____ _____

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PRIMARY COMMERCIAL INSURANCE *(Please bring card to visit)*

Insured: _____ Social Security #: _____ Date of Birth: _____

Relationship to Child: _____ Home Phone #: _____ Work Phone #: _____

Insurance Company: _____ Identification #: _____ Group #: _____

Employer: _____

Employer Address: _____

Street *City* *State* *Zip*

SECONDARY COMMERCIAL INSURANCE *(Please bring card to visit)*

Insured: _____ Social Security #: _____ Date of Birth: _____

Relationship to Child: _____ Home Phone #: _____ Work Phone #: _____

Insurance Company: _____ Identification #: _____ Group #: _____

Employer: _____

Employer Address: _____

Street *City* *State* *Zip*

MEDICAID *(Please bring card to visit)*

Name of Plan: ☐ Traditional ☐ PCCM ☐ Amerigroup ☐ Amerigroup CHIPs ☐ Parkland
☐ Parkland CHIPs/Kidsfirst ☐ Unicare ☐ Unicare CHIPs ☐ Aetna CHIPs ☐ Superior

CHIPS = Children's Health Insurance Program; PCCM = Primary Care Case Management

Identification #: _____

**Please note that we must obtain authorization for therapy visits for your child with Medicaid. Each plan requires a separate authorization, so when your child changes from one plan to another, therapy visits will be discontinued until new authorization is received. This process can take a few days to a couple of weeks, depending on the timely response from your child's physician and the plan itself.

_____ _____

****Parent/Guardian Signature** **Date**

Therapist Initials: _____ _____ _____ _____ _____ _____

HEALTH HISTORY

Accident information:

Is the admission related to an accident? ☐ No ☐ Yes If "Yes", please answer the following questions:

Date & Time accident occurred:_____ Location of accident *(including the County)*: _____

Description of accident: _____

_____

Does your child have any medical conditions related to the following:

Heart	☐ No	☐ Yes	Bone / Joint Injuries	☐ No	☐ Yes	Cancer	☐ No	☐ Yes
Lungs	☐ No	☐ Yes	Cytomegalovirus (CMV)	☐ No	☐ Yes	High Blood Pressure	☐ No	☐ Yes
Kidneys	☐ No	☐ Yes	Seizure	☐ No	☐ Yes	Difficulty Eating	☐ No	☐ Yes
Digestive System	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes			
Surgery	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes			

If "Yes", please explain: _____

_____

Does your child have any other medical conditions, contagious or otherwise, that we should know about? ☐ No ☐ Yes

If "Yes", please explain: _____

_____

_____

Current Weight: _____ Height: _____ Head Circumference: _____

Has child had **unintentional** weight gain or loss of more that 5 pounds in the last 12 months. If "Yes", please describe:

_____

SURGERIES / PROCEDURES / HOSPITALIZATIONS

Date	Procedure	Physician / Hospital

PLEASE LIST ANY OTHER SPECIALISTS THAT YOUR CHILD CURRENTLY SEES OR IS SCHEDULED TO SEE:

Physician: _____ Phone #: _____

Physician: _____ Phone #: _____

Physician: _____ Phone #: _____

Physician: _____ Phone #: _____

Physician: _____ Phone #: _____

Has your child ever been in "Isolation" during a hospital stay? No Yes If "Yes", please explain below:

_____

_____

Therapist Initials: _____ _____ _____ _____ _____ _____

Please check "**Yes**" or "**No**" for the following statements and complete the "Comments" section after the questions if needed.

YES	NO	HEALTH
☐	☐	Child was born before due date; Number of weeks premature: _____
☐	☐	Complications during pregnancy and/or delivery
☐	☐	Child has been treated for a Metabolic Disease
☐	☐	Child has frequent headaches
☐	☐	Child has history of ear infections
☐	☐	Child has sleep problems
☐	☐	Child experiences diarrhea frequently or is often constipated
☐	☐	Child as an extremely limited diet
☐	☐	Child has recent injury or regression; Date of injury: _____
☐	☐	Child is considered healthy

Comments: _____

_____

Please check the tests below that your child has **received** or is **scheduled for:**

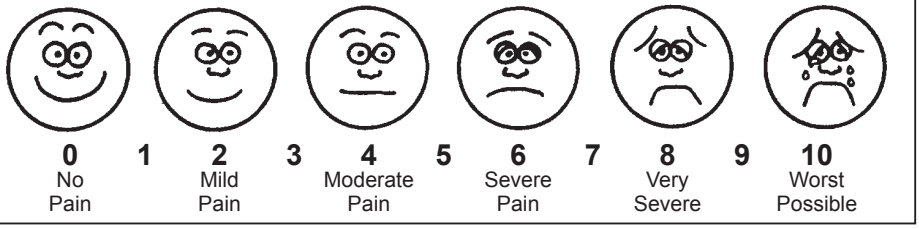
TEST	DATE TESTED	REASON FOR TESTING
☐ Auditory Brain Stem Response		
☐ Electroencephalogram (EEG) - (Brain)		
☐ Vision Assessment at School		
☐ Vision Assessment by Ophthalmologist		
☐ Hearing Assessment		
☐ Immunoglobulin E (IgE) Allergy Test		
☐ Magnetic Resonance Imaging (MRI)		
☐ Video Swallow Study		
☐ Other: _____		

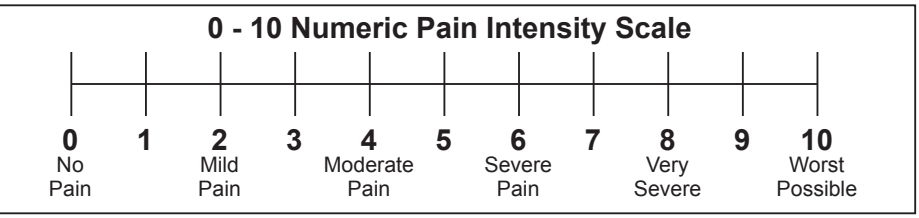
PAIN ASSESSMENT

Is your child having Pain/Discomfort now or experienced pain recently: ☐ No ☐ Yes

Please be prepared to answer detailed information during the evaluation about the pain your child is experiencing.

Overall Pain Level
Please circle the most appropriate number under the smiley faces in the picture.





Therapist Initials: _____ _____ _____ _____ _____ _____

LEARNING / EDUCATIONAL NEEDS

What is your child's current educational level?

☐ Pre-K ☐ Kindergarten ☐ 1st Grade ☐ 2nd Grade ☐ 3rd Grade ☐ 4th Grade ☐ Other: _____

Average Grade: ☐ A ☐ B ☐ C ☐ D Name of School District: _____

Name of School: _____

☐ Regular Classroom ☐ Resource Classroom ☐ Self-Contained

What Services does your child receive at school? **(Include Therapist name and provide Individualized Education Program (IEP) Reports)**

Service	Therapist Name	Service	Therapist Name
☐ Occupational Therapy		☐ Speech Therapy	
☐ Physical Therapy		☐ Other: _____	

Are there factors that would affect you or your child's ability to learn? Please check any that apply:

	You	Child		You	Child		You	Child
Hearing	☐	☐	Stress	☐	☐	Comprehension	☐	☐
Reading	☐	☐	Limited Attention Span	☐	☐	Religious	☐	☐
Writing	☐	☐	Written Instructions	☐	☐	Cultural	☐	☐
Vision	☐	☐	Practice	☐	☐	Language	☐	☐
Pain	☐	☐	Memory Loss	☐	☐	Interpreter Needed	☐	☐
	☐	☐		☐	☐	What Language: _____		

How would you like to be trained to work on your child's therapy at home? Please check any that apply:

☐ **Verbal Instructions** ☐ **Demonstration** ☐ **Other:** _____

DEVELOPMENTAL NEEDS

Has your child received therapy services in the past? ☐ No ☐ Yes If "Yes", When and Where: _____

_____

_____

Is your child currently involved in extra-curricular or recreational activities outside of school? ☐ No ☐ Yes If "Yes", List Here:

_____

_____

At what ages were the following developmental skills attained:

Sat at _____ months	Crawled on hands and knees _____ months	Rode bicycle without training wheels _____ years
Walked at _____ months	Said first meaningful word _____ months	Demonstrated knowledge of right & left _____ years
		Completed Toilet Trained at _____ years

Yes	No	Motor Functions
☐	☐	Child appears clumsy or topples without cause
☐	☐	Child has difficulty grasping a pencil or crayon
☐	☐	Child has difficulty throwing a ball *(And is at least three (3) years old)*
☐	☐	Child has difficulty catching a ball *(And is at least three (3) years old)*
☐	☐	Child can walk independently
☐	☐	Motor skills are at age level

Comments:

Therapist Initials: _____ _____ _____ _____ _____ _____

DEVELOPMENTAL NEEDS (continued)

Yes	No	Communicating with You
☐	☐	Cries when he/she wants something
☐	☐	Points or gestures when he/she wants something
☐	☐	Makes sounds to try to communicate his/her needs
☐	☐	Uses one-word (1) utterances to communicate
☐	☐	Uses two- to three-word (2-3) utterances to communicate
☐	☐	Uses 3-plus words to communicate
☐	☐	Uses long sentences to communicate
☐	☐	Family understands the child's speech
☐	☐	People outside the family understand the child's speech

Comments:

Yes	No	Understanding Language
☐	☐	Child understands commonly used spoken words *(i.e. hello, ball, bye)*
☐	☐	Child responds to his/her name
☐	☐	Child focuses on pictures in books
☐	☐	Child points to picture in book upon request
☐	☐	Answers simple "Who", "What", "Where" and "Why" questions
☐	☐	Hears and understands most of what is said at home and school

Comments:

Yes	No	Social / Daily Routine
☐	☐	Child has rigid daily routine or an outburst will occur
☐	☐	Child requires medication for behavior control
☐	☐	Child plays appropriately with age-level peers
☐	☐	Child plays with toys appropriately for his/her age

Comments:

Yes	No	Eating / Swallowing
☐	☐	Child gags often on certain foods
☐	☐	Child avoids certain textures/types/colors of food
☐	☐	Child has difficulty chewing or swallowing food in a timely manner
☐	☐	Child coughs frequently on food or drink
☐	☐	Child eats age-appropriate foods
☐	☐	Child independently uses all utensils age-appropriately *(i.e. spoon, cup, straw)*
☐	☐	Child measures with appropriate weight gain and height for his/her age

Comments:

Therapist Initials: _____ _____ _____ _____ _____ _____

DEVELOPMENTAL NEEDS (continued)

Yes	No	Tactile
☐	☐	Child objects to tags at the back of neck or clothing
☐	☐	Child avoids getting messy *(i.e. finger-painting)*
☐	☐	Child avoids wearing shoes or loves to be barefoot
☐	☐	Child reveals distress during grooming activities *(i.e. brushing hair and/or teeth)*
☐	☐	Child has decreased awareness of pain
☐	☐	Child avoids playing in the grass and/or sand

Comments:

Yes	No	Vestibular Functions
☐	☐	Child gets car sick
☐	☐	Child avoids movement *(i.e. does not allow feet to leave the ground)*
☐	☐	Child tends to stand rather than sit to eat
☐	☐	Child is obsessive about swinging, spinning or bouncing
☐	☐	Child gets dizzy after spinning
☐	☐	Child twirls/spins self frequently throughout the day

Comments:

Yes	No	Cognitive Functions
☐	☐	Child independently says or sings familiar rhymes and songs
☐	☐	Child solves most routine problems with minimal adult assistance
☐	☐	When given the initial prompt, the child remembers situations and events that occurred earlier in the day
☐	☐	Child plays appropriately with age-level peers
☐	☐	Child consistently recognizes familiar toys or people
☐	☐	Child interacts with peers for only a short period or plays side-by-side with peers
☐	☐	Child remembers location of favorite toy or object after a short period of time
☐	☐	Child plays with toys appropriate for his/her age
☐	☐	Child requires help in dialing a number to place a call
☐	☐	Child has to have a rigid daily routine or an outburst will occur
☐	☐	Child answers the telephone and converses

Comments:

1. What is your child's diagnosis?

2. Why is your child coming to be evaluated?

3. What improvements do you hope your child will make with therapy?

Therapist Initials: _____ _____ _____ _____ _____ _____

COMMUNICABLE DISEASE / IMMUNIZATION SCREEN

Are your child's immunizations up-to-date? ☐ Yes ☐ No If "No", please contact your primary care physician.

In addition, we need for you to understand that the health and safety of all children and staff must be protected, so please be aware of the following:

1. YOUR CHILD MAY NOT VISIT OR RECEIVE TREATMENT IF THE CHILD HAS ANY OF THE DISEASES/SYMPTOMS LISTED BELOW.	*Initial Here*
2. THESE DISEASES COULD BE HARMFUL TO THE CHILDREN WHO RECEIVE TREATMENT AT OUR CHILDREN'S HOUSE AT BAYLOR.	*Initial Here*
3. PLEASE LET STAFF KNOW IF YOUR CHILD IS EXPOSED TO OR BECOMES ILL WITH ANY OF THE DISEASES OR SYMPTOMS LISTED BELOW.	*Initial Here*

Has your child been exposed to ANY of these communicable diseases or had ANY of these symptoms TODAY or IN THE LAST 24 HOURS?

Diarrhea	☐ No	☐ Yes	Cold Sores	☐ No	☐ Yes
Nausea and Vomiting	☐ No	☐ Yes	Impetigo	☐ No	☐ Yes
Fever	☐ No	☐ Yes	Infected or Draining Sores	☐ No	☐ Yes
Cough	☐ No	☐ Yes	Rash from Unknown Cause	☐ No	☐ Yes
Running Nose	☐ No	☐ Yes	Pink Eye	☐ No	☐ Yes
Sore Throat	☐ No	☐ Yes	Night Sweats, Fever, Weight Loss, Coughing up blood	☐ No	☐ Yes
Measles	☐ No	☐ Yes	Chick Pox	☐ No	☐ Yes
Mumps	☐ No	☐ Yes	Tuberculosis	☐ No	☐ Yes
MRSA (Methicillin-Resistant Staphylococcus Aureus)	☐ No	☐ Yes			

By signing below, I certify that I have answered all questions with accurate and complete information. I understand that it is my responsibility to promptly notify Our Children's House at Baylor if I discover any information is or becomes inaccurate or in complete. I hereby release Our Children's House at Baylor from all liability for any action based on inaccurate or incomplete information both now and in the future that I have failed to notify Our Children's House at Baylor about.

***Parent/Guardian Signature**		***Date***	***Time***
Staff Signature	*Initials*	*Date*	*Time*
Staff Signature	*Initials*	*Date*	*Time*
Staff Signature	*Initials*	*Date*	*Time*
Staff Signature	*Initials*	*Date*	*Time*