



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

**OUR CHILDREN'S HOUSE AT BAYLOR**



OCH-51477 (Rev. 10/11)

**PATIENT INFORMATION FORM - NEW PATIENT  
 OUTPATIENT SERVICES**

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

**OUR CHILDREN'S HOUSE AT BAYLOR**



OCH-51477 (Rev. 10/11)

**PATIENT INFORMATION FORM - NEW PATIENT  
 OUTPATIENT SERVICES**

### 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	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bone / Joint Injuries	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Lungs	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Cytomegalovirus (CMV)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	High Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Kidneys	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Seizure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Difficulty Eating	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Digestive System	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> 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: \_\_\_\_\_

**OUR CHILDREN'S HOUSE AT BAYLOR**



OCH-51477 (Rev. 10/11)

**PATIENT INFORMATION FORM - NEW PATIENT  
OUTPATIENT SERVICES**

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

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

Comments: \_\_\_\_\_

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

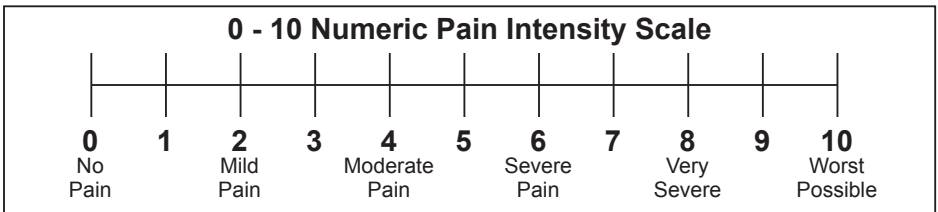
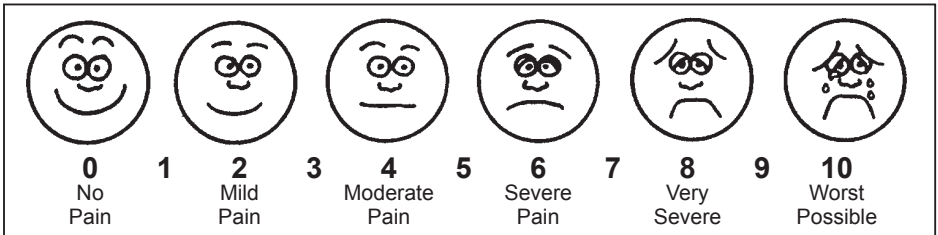
TEST	DATE TESTED	REASON FOR TESTING
<input type="checkbox"/> Auditory Brain Stem Response		
<input type="checkbox"/> Electroencephalogram (EEG) - (Brain)		
<input type="checkbox"/> Vision Assessment at School		
<input type="checkbox"/> Vision Assessment by Ophthalmologist		
<input type="checkbox"/> Hearing Assessment		
<input type="checkbox"/> Immunoglobulin E (IgE) Allergy Test		
<input type="checkbox"/> Magnetic Resonance Imaging (MRI)		
<input type="checkbox"/> Video Swallow Study		
<input type="checkbox"/> 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: \_\_\_\_\_

**OUR CHILDREN'S HOUSE AT BAYLOR**



OCH-51477 (Rev. 10/11)

**PATIENT INFORMATION FORM - NEW PATIENT  
OUTPATIENT SERVICES**

**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
<input type="checkbox"/> Occupational Therapy		<input type="checkbox"/> Speech Therapy	
<input type="checkbox"/> Physical Therapy		<input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	Stress	<input type="checkbox"/>	<input type="checkbox"/>	Comprehension	<input type="checkbox"/>	<input type="checkbox"/>
Reading	<input type="checkbox"/>	<input type="checkbox"/>	Limited Attention Span	<input type="checkbox"/>	<input type="checkbox"/>	Religious	<input type="checkbox"/>	<input type="checkbox"/>
Writing	<input type="checkbox"/>	<input type="checkbox"/>	Written Instructions	<input type="checkbox"/>	<input type="checkbox"/>	Cultural	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>	Practice	<input type="checkbox"/>	<input type="checkbox"/>	Language	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	Interpreter Needed	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	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
<input type="checkbox"/>	<input type="checkbox"/>	Child appears clumsy or topples without cause
<input type="checkbox"/>	<input type="checkbox"/>	Child has difficulty grasping a pencil or crayon
<input type="checkbox"/>	<input type="checkbox"/>	Child has difficulty throwing a ball (And is at least three (3) years old)
<input type="checkbox"/>	<input type="checkbox"/>	Child has difficulty catching a ball (And is at least three (3) years old)
<input type="checkbox"/>	<input type="checkbox"/>	Child can walk independently
<input type="checkbox"/>	<input type="checkbox"/>	Motor skills are at age level

Comments: \_\_\_\_\_

Therapist Initials: \_\_\_\_\_

**OUR CHILDREN'S HOUSE AT BAYLOR**



OCH-51477 (Rev. 10/11)

**PATIENT INFORMATION FORM - NEW PATIENT  
OUTPATIENT SERVICES**

**DEVELOPMENTAL NEEDS (continued)**

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

Comments:

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

Comments:

Yes	No	Social / Daily Routine
<input type="checkbox"/>	<input type="checkbox"/>	Child has rigid daily routine or an outburst will occur
<input type="checkbox"/>	<input type="checkbox"/>	Child requires medication for behavior control
<input type="checkbox"/>	<input type="checkbox"/>	Child plays appropriately with age-level peers
<input type="checkbox"/>	<input type="checkbox"/>	Child plays with toys appropriately for his/her age

Comments:

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

Comments:

Therapist Initials: \_\_\_\_\_

**OUR CHILDREN'S HOUSE AT BAYLOR**



OCH-51477 (Rev. 10/11)

**PATIENT INFORMATION FORM - NEW PATIENT  
OUTPATIENT SERVICES**

DEVELOPMENTAL NEEDS (continued)		
Yes	No	Tactile
<input type="checkbox"/>	<input type="checkbox"/>	Child objects to tags at the back of neck or clothing
<input type="checkbox"/>	<input type="checkbox"/>	Child avoids getting messy ( <i>i.e. finger-painting</i> )
<input type="checkbox"/>	<input type="checkbox"/>	Child avoids wearing shoes or loves to be barefoot
<input type="checkbox"/>	<input type="checkbox"/>	Child reveals distress during grooming activities ( <i>i.e. brushing hair and/or teeth</i> )
<input type="checkbox"/>	<input type="checkbox"/>	Child has decreased awareness of pain
<input type="checkbox"/>	<input type="checkbox"/>	Child avoids playing in the grass and/or sand
Comments:		
Yes	No	Vestibular Functions
<input type="checkbox"/>	<input type="checkbox"/>	Child gets car sick
<input type="checkbox"/>	<input type="checkbox"/>	Child avoids movement ( <i>i.e. does not allow feet to leave the ground</i> )
<input type="checkbox"/>	<input type="checkbox"/>	Child tends to stand rather than sit to eat
<input type="checkbox"/>	<input type="checkbox"/>	Child is obsessive about swinging, spinning or bouncing
<input type="checkbox"/>	<input type="checkbox"/>	Child gets dizzy after spinning
<input type="checkbox"/>	<input type="checkbox"/>	Child twirls/spins self frequently throughout the day
Comments:		
Yes	No	Cognitive Functions
<input type="checkbox"/>	<input type="checkbox"/>	Child independently says or sings familiar rhymes and songs
<input type="checkbox"/>	<input type="checkbox"/>	Child solves most routine problems with minimal adult assistance
<input type="checkbox"/>	<input type="checkbox"/>	When given the initial prompt, the child remembers situations and events that occurred earlier in the day
<input type="checkbox"/>	<input type="checkbox"/>	Child plays appropriately with age-level peers
<input type="checkbox"/>	<input type="checkbox"/>	Child consistently recognizes familiar toys or people
<input type="checkbox"/>	<input type="checkbox"/>	Child interacts with peers for only a short period or plays side-by-side with peers
<input type="checkbox"/>	<input type="checkbox"/>	Child remembers location of favorite toy or object after a short period of time
<input type="checkbox"/>	<input type="checkbox"/>	Child plays with toys appropriate for his/her age
<input type="checkbox"/>	<input type="checkbox"/>	Child requires help in dialing a number to place a call
<input type="checkbox"/>	<input type="checkbox"/>	Child has to have a rigid daily routine or an outburst will occur
<input type="checkbox"/>	<input type="checkbox"/>	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: _____		

**OUR CHILDREN'S HOUSE AT BAYLOR**



OCH-51477 (Rev. 10/11)

**PATIENT INFORMATION FORM - NEW PATIENT  
OUTPATIENT SERVICES**



### 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:

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

**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	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Cold Sores	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Nausea and Vomiting	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Impetigo	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Infected or Draining Sores	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Cough	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Rash from Unknown Cause	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Running Nose	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Pink Eye	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Sore Throat	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Night Sweats, Fever, Weight Loss, Coughing up blood	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Measles	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Chick Pox	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Mumps	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Tuberculosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
MRSA (Methicillin-Resistant Staphylococcus Aureus)	<input type="checkbox"/> No	<input type="checkbox"/> 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 incomplete. 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.

<b>**Parent/Guardian Signature</b>	<b>Date</b>	<b>Time</b>
Staff Signature	Initials	Date
Staff Signature	Initials	Date
Staff Signature	Initials	Date
Staff Signature	Initials	Date

### OUR CHILDREN'S HOUSE AT BAYLOR



OCH-51477 (Rev. 10/11)

**PATIENT INFORMATION FORM - NEW PATIENT  
OUTPATIENT SERVICES**