2000 E. Chapman Avenue, Suite 100, Fullerton, CA 92831-4106

Pediatric Patient Information

Last Name: ______________________ First Name: ______________ Middle Initial: _____

Father's Name: ______________________ Mother's Name: ______________________

Current Home Address: ____

City: ______________ State: ________ Zip: ______________

Home Phone:( ) - Cell Phone:( ) - Work Phone:( ) -

Date of Birth: ____/____/_______ Sex: (circle one) M / F SS #:______-_____-_________

Responsible Party SS #: ________-_____-___________ Responsible DL #: __________________

Language used at home: ☐ English ☐ Spanish ☐ Other: ______________________

School or Program of Attendance: ______________________ Phone #: ( ) -

Referring Doctor / Source: ____

Referral Address: ____

City: ______________ State: ________ Zip: ______________

Referral Phone: ( ) - Referral Fax:( ) -

Primary Insurance: ______________________________________ N/A ☐

ID #: ______________________ Group #: ______________________

Address: ____

City: ______________ State: ________ Zip: ______________

Phone: ( ) -

Secondary Insurance: ______________________________________ N/A ☐

ID #: ______________________ Group #: ______________________

Address: ____

City: ______________ State: ________ Zip: ______________

Phone: ( ) -

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Medical History

Last Name: ____________________________ First Name: _________________ MI: ______________

Pregnancy and Birth History

☐ Full Term ☐ Premature (______________ weeks of gestation) Birth Weight: _____lbs ____oz

Were there any extraordinary conditions before, during, or after the birth? For example, high feves, measels, use of drugs, alcolol, or prescription medicines. Explain: _______________________________

Child's Health History

Does your child now have or ever had any of the following?

Illnesses at birth (List: ____)	yes / no
Allergies (to what? ____)	yes / no
Asthma	yes / no
Seizures	yes / no
Hospitalizations (When ?____)	yes / no
Surgeries (for what and when? ________________________	yes / no
Ear Infections (When? ____)	yes / no
Other: ____	yes / no

Is your child taking any medications? (Please list): ____

Daily Activities

Does your child have problems with any of the following

Chewing	yes / no	Picking up small things	yes / no
Swallowing	yes / no	Throwing	yes / no
Balance	yes / no	Kicking	yes / no
Crawling	yes / no	Catching	yes / no
Walking	yes / no	Babbling	yes / no
Sitting	yes / no	Talking	yes / no
Jumping	yes / no	Behavior	yes / no

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Child's Development

When did your child begin to:

Sit Alone? _______________________________________	
Crawl? ____	
Walk? ____	
Babble? ____	
Say 1st Words? __________________________	What were they? _______________________________
Put Two Words Together? _________________	What were they? _______________________________
Finish Toilet Training? ______________________________	

Other Examinations

Has your child had a recent vision examination?	yes / no	results? ___________________
Has your child had a recent hearing examination?	yes / no	results? ___________________
Has your child had any evaluations by a medical or educational specialist?	yes / no	results? ___________________

Describe your current concerns about your child:____

____

____

Describe your child's strong likes:____

Describe your child's strong dislikes: ____

What are your child's favorite toys: ____

Parent's Signature: __________________________________ Date: ___________________________

866-GO-MAXUM (866-466-2986) • (714) 870-1744 • (714) 870-1784 (fax)
www.maxumtherapy.com

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maXum Physical Therapy

Consent Form

Patient Name: ______________________ Phone # Cell (___)_____________

Home (___)_____________

Emergency Contact: Work (___)_____________

Relationship: ______________________

Release of Information

The undersigned hereby authorizes maXum Physical Therapy, inc. to release any or all information to employers and insurance companies, who may be liable to the patient or maXum Physical Therapy for payment of services provided to the patient.

Assignment of Benefits

The undersigned hereby authorizes treatment by maXum Physical Therapy, inc. and assigns maXum Physical Therapy and all benefits payable for the services provided and billed to said company for payment. Any copays, coinsurance, or denied claims are the responsibility of the patient for payment.

______________________________ ______________

Signature Date