CHPT
Complete Hometown Physical Therapy

□ 201A North Main St, Hallettsville, TX 77964 (361) 798-3500
□ 105 Boehm Dr, Shiner, TX 77984 (361) 594-8301
□ 206 Hwy 77A South, Yoakum, TX 77995 (361) 407-5091
www.completehometownpt.com

Patient Demographic Sheet

Patient Name: _____ **Gender** _____

Date of Birth _____ **Age** _____

Name of Person Completing Form _____

Phone # _____

Mailing Address _____

City _____ **State** _____ **Zip** _____

City of Birth _____ **Hospital** _____

Diagnosis (if any, please list diagnostic codes if you know it) _____

_____

Referral Source:_____

Guardian #1

Name _____ **Relationship** _____

Address (if different than patient) _____

_____

Phone #1 _____ **Home / Cell / Work**

Phone #2 _____ **Home / Cell / Work**

Email address _____

Occupation: _____

Guardian #2

Name _____ **Relationship** _____

Address (if different than patient) _____

_____

Phone #1 _____ **Home / Cell / Work**

Phone #2 _____ **Home / Cell / Work**

Email address _____

Occupation: _____

Name and Ages of Child's Siblings:

REASON FOR REFERRAL/PRIMARY REASON FOR SEEKING THERAPY:

Please describe YOUR vision for your child's individual educational and emotional needs:

- Please try to provide at least 24 hours notice if you must cancel or reschedule an appointment so that we may provide another patient with that appointment opportunity. Exceptions are for Monday appointments when 24 hour notice is not possible or when your appointment is the day after a holiday.

- I hereby give authorization for payment of medical and/or auto insurance benefits and/or legal settlement payments to be made directly to Complete Hometown Physical Therapy, and for any assisting therapist employed by or contracted with Complete Hometown Physical Therapy.

- I understand that I am financially responsible for all charges, whether or not they are covered by my insurance, provided I am notified in advance that any proposed service or therapy/treatment/procedure may not be covered by patient's insurance provider(s).

- I understand that all copay, coinsurance and deductible amounts are due and payable at the time of service, unless a payment arrangement has been made with the billing. If the explanation of benefits from the insurer(s) shows a remaining patient balance due, the patient will be billed accordingly.

- In the event of a default in payment, the prevailing party in any lawsuit or mediation will be entitled to recover reasonable attorney fees and actual costs of collection.

- I hereby authorize Complete Hometown Physical Therapy to release any and all information necessary to secure payment of benefits to only those parties legally entitled to receive information for purposes of receiving payment of existing balances or for authorization for continuation of services as may be necessary or requested by the patient's insurer(s).

- I agree that a photocopy of this agreement shall be as valid as the original.

Thank you for you cooperation.

Patient (if minor – Parent or Legal Guardian) Signature: _____

Date: _____

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Patient Medical History

Name: _____ Birth weight _____

Please mark all that apply:

____ born C-section	____ born vaginally	____ full term pregnancy
____ premature Explain/how many weeks?	____ spent time in NICU Explain/how many weeks?	____ complicated pregnancy/delivery Explain/how many weeks?
_____	_____	_____
_____	_____	_____
_____	_____	_____

____ history of NG feeding tube	____ history of G-tube feedings	____ history of reflux
____ history of ear infections	____ current PE tubes	____ history of aspiration
____ history of PE tubes	____ asthma	____ food allergies
____ tonsillectomy	____ adenoidectomy	____ falls frequently
____ tongue-tie/lip-tie	____ sleeping problems	____torticollis

Please explain any of the items checked above (i.e. age of incident, complications, etc.)

_____

_____

_____

Please list your child's doctor(s):

Pediatrician _____

Phone # _____

Specialists the child is followed by (ex: Neurologist, Nutritionist, Allergist, etc.)

Name: _____ **Specialty** _____ **Phone #**_____

Name: _____ **Specialty** _____ **Phone #**_____

PRIOR TREATMENT INFORMATION

Has your child ever had speech, physical or occupational therapy prior to this evaluation? _____

If yes, please mark all that apply ____ speech therapy ____ physical therapy _____occupational

How long did your child receive therapy? _____

When did your child receive therapy? _____

Where did your child receive therapy? _____

SCHOOL/EDUCATION

Is your child in school? _____ If yes, what school? _____

What grade is he/she enrolled in? _____ Has he/she repeated a grade? _____
If yes, what grade? _____

Is he/she enrolled in: _____ PPCD _____ Special Education _____ Head Start _____ Other

What is your child's teacher's name? _____

MEDICATIONS

Medication:	How often does your child take this medication?	Why does he/she take the medication?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary language(s) spoken at home: _____

Does your child have **hearing** problems? If yes, please explain**.** _____

_____

Last hearing screen (month/year) _____ Results: ___ normal ___abnormal ____other_____

Where was hearing examined? _____

Does your child use hearing aid/cochlear implant? _____

Does your child have **vision** problems? If yes, please explain. _____

Last vision screen (month/year) _____ Results: ___ normal ___abnormal ____ other_____

Where was vision examined? _____ Does your child wear glasses/contacts? _____

Does your child use any other adaptive equipment? If yes, please explain. _____

_____

Does your child have any dental problems? If yes, please explain. _____

_____Last dental cleaning (month/year) _____

Please mark all that apply for allergies:

_____ seasonal: _____

_____ food: _____

_____ medicine: _____

_____ insects/animals: _____

_____ other: _____

Surgeries/Hospitalizations/Visits to the Emergency Room:

Month/Year:	**Reason:**	**Length of Stay:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

DEVELOPMENTAL MILESTONES

At what age did your child first…?
(Please list an age next to each developmental milestone in months or years)

Roll over _____ months *or* _____ years

Sit up _____ months *or* _____ years

Crawl _____ months *or* _____ years

Stand Alone _____ months *or* _____ years

Take first step _____ months *or* _____ years

Smile _____ months *or* _____ years

Cutting with scissors _____ months *or* _____ years

Babble _____ months *or* _____ years

Say 1st word _____ months *or* _____ years

Combine 2 words/phrases _____ months *or* _____ years

Sleep through the night _____ months *or* _____ years

Toilet trained _____ months *or* _____ years

Dress himself/herself _____months *and /or* years_____

Eating with utensils _____ months *or* _____ years

COMMUNICATION

Does your child…? (Please mark all that apply.)

____ Respond correctly to who, what, when, where, why, how?

____ Repeat sounds, words, phrases over and over?

____ Respond correctly to yes/no questions?

____ Retrieve or point to common objects upon request (ex: ball, cup, shoes)?

____ Follow simple instructions (shut the door, get your shoes)?

____ Understand what you are saying?

Your child currently communicates using (please mark all that apply)…

____ body language (ex: pointing or pulling you to what they want)

____ sounds (vowels or grunting)

____ words (ex: kitty, up, shoe)

____ 2-4 word sentences

____ sentences longer than 4 words

____ other _____

SOCIAL SKILLS

Please mark any statements that describe your child.

____ difficulty making or maintaining friendships

____ difficulty sharing/taking turns

____ unable to interpret social cues

____ does not respect personal space of others

____ prefer to play alone

____ attend social outings (ex: going to eat at a restaurant, birthday parties, running errands)

_____

FEEDING

Does your child have any feeding difficulties? If yes, please explain. _____

_____

Please mark all that apply:

____ drink from an open cup

____ drink from a straw

____ use a fork/spoon

____ choke or cough on foods/liquids

____ gag and/or vomit while eating

____ picky eater

____ wet/gurgly voice quality

____ difficulty chewing

____ difficulty transitioning between food textures (e.g., bottle to purees, purees to solids, soft solids to resistive foods)

____ diet limited to less than 10 foods

____ putting too much food in his/her mouth

____ significantly aversive to specific textures *(please list)*

_____

MOTOR SKILLS

Does your child…? (Please mark all that apply.)

____Use zippers and fasten buttons

____Take off own socks and shoes

____Open containers

____ Walk up/down stairs

_____Walks on his/her toes

____Put on socks/shoes

____Brush his/her own teeth

____ Challenges with coloring or hand-writing

____ Frequently trip on his/her own feet

____Seem unsure of how to move his/her body (is clumsy and awkward)

SENSORY PROCESSING

Please mark any statements that describe your child.

____ difficulty with transitions/changes

____ overly emotional/sensitive

____ difficulty calming from tantrums

____ difficulty separating

____frequently bumps into objects and people

____ fearful of playground equipment

____ poor frustration tolerance

____ unwilling to try new activities

____ difficulty sleeping through the night

____ difficulty sitting still

____ complains about having teeth/hair brushed

____ fearless on playground equipment

____ impulsive

____poor attention

____ aggressive

____ avoids messy play

____ inappropriate behaviors (explain) _____

____ self-abusive behaviors (explain) _____

____ frequent tantrums/meltdowns (explain) _____

_____ _____

SIGNATURE OF PERSON ANSWERING QUESTIONS **DATE**

_____

RELATIONSHIP TO PATIENT

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Consents and Privacy Acknowledgment

Please initial each item.

_____ **Consent for Care and Treatment:** As the child's parent or legal guardian, I hereby consent to necessary evaluation, procedures and/or treatments prescribed by my child's therapist as necessary in her judgment. I understand that my child is under the care and supervision of the therapist.

_____ **Consent for Student Observation:** I understand that Complete Hometown Physical Therapy supports the education of students in Speech-Language Pathology and that students may observe or participate with clients in therapy, under supervision.

____ *I consent to have students in the same treatment area with my child.*

____ *I do not consent to have students in the same treatment area with my child.*

_____ **Acknowledgment of Notice of Privacy Practices:** I acknowledge Complete Hometown Physical Therapy will use and disclose my personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law. A copy of the Notice of Privacy Practices was provided to me, if requested, with further detailed information about how protected medical information is used and/or disclosed about my child for treatment, payment, healthcare operations, and as otherwise allowed by law.

____ **Photography and Video Release Form:** I hereby authorize Complete Hometown Physical Therapy (CHPT) to photograph or video my child for the purposes of treatment, education, and professional reasons. I understand that my child may be in group pictures or videos that may also be reviewed by others outside of CHPT. I also understand that if pictures of my child are used for advertisement or marketing purposes, CHPT will request consent from me prior to use. This authorization is valid for the duration of my child's therapy from the date signed below. I understand that I may revoke this authorization at any time, but will not hold the therapist and/or staff of CHPT responsible for pictures or videos already taken of my child.

_____ _____

Signature of Child's Parent/Legal Guardian **Printed Name**

_____

Date