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## **Patient Demographic Sheet**

Patient Name:		Gender	
Date of Birth		Age	
Name of Person Completing Fo	rm		
Phone #			
Mailing Address			
City	State	Zip	
City of Birth	Hospita	al	
Diagnosis (if any, please list diag	nostic codes if you know it)		
Referral Source:			
Guardian #1			
Name		Relationship	
Address (if different than patient)	l		
		Home / Cell / Work	
Phone #2		Home / Cell / Work	
Email address			
Occupation:			
Guardian #2			
Name		Relationship	
	)		
Phone #1		Home / Cell / Work	
Phone #2		Home / Cell / Work	
Email address			
Occupation:			

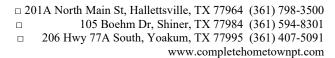
Name and Ages of Child's Siblings:	
REASON FOR REFERRAL/PRIMARY REASON FOR SEEKING THERAPY:	
Please describe YOUR vision for your child's individual educational and emotional needs:	

- 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.

Date: \_\_\_\_\_

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





# **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 chec	ked above (i.e. age of incident, complica	tions, etc.)
Please list your child's doctor(s):		
Pediatrician		<del></del>
Phone #		
Specialists the child is followed by	(ex: Neurologist, Nutritionist, Allergis	t, etc.)
Name:	Specialty	Phone #
Name:	Specialty	Phone #

## PRIOR TREATMENT INFORMATION

Has your child ever had speech, physic	al or occupational therapy prior to this	evaluation?
If yes, please mark all that apply	_ speech therapy physical therap	pyoccupational
How long did your child receive therap	y?	
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 If yes, what grade?	a 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 <b>hearing</b> problems? If	yes, please explain.	
Last hearing screen (month/year)		
Where was hearing examined?		
Does your child use hearing aid/cochlear	implant?	

Does your child have <b>vision</b> problems? If yes, please ex	plain	
Last vision screen (month/year)	Results:normalabnormalother	
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, pl	ease explain.	
	Last dental cleaning (month/year)	
Please mark all that apply for allergies:		
seasonal:		
food:		
medicine:		
insects/animals:		
Surgeries/Hospitalizations/Visits to the Emergency Foundation of the Emergency Foundat	Length of Stay:	
	MENTAL MILESTONES ge did your child first?	
(Please list an age next to each	n developmental milestone in months or years)	
oll over months or years	Babble months or years	
it up months or years	Say 1 <sup>st</sup> word months or years	
Crawl months or years	Combine 2 words/phrases months or years	
tand Alone months or years	Sleep through the night months or years	
Take first step months or years	<b>Toilet trained</b> months <i>or</i> years	
Smile months or years	<b>Dress himself/herself</b> months and /or years	
Cutting with scissors months or years	Eating with utensils months or years	

COMMUNICATION

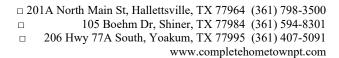
Does your child...? (Please mark all that apply.)

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 describ	pe your child.	
difficulty making or maintaining friendships	difficulty sharing/taking turns	
unable to interpret social cues	oes not respect personal space of others	
prefer to play alone		
attend social outings (ex: going to eat at a restaurant, birthday parties, ru	unning 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 stray	w use a fork/spoon	
choke or cough on foods/liquids gag and/or vomit	while eating picky eater	
wet/gurgly voice quality difficulty chewing	g	
difficulty transitioning between food textures (e.g., bottle to purees, pur	rees to solids, soft solids to resistive foods)	
diet limited to less than 10 foods putting too much	food in his/her mouth	

MOTOR SKILLS

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

Use zippers and fasten buttons	Put on socks/shoes		
Take off own socks and shoes	Brush his/her own teeth		
Open containers	Challenges with coloring or hand-wr	iting	
Walk up/down stairs	Frequently trip on his/her own feet		
Walks on his/her toes	Seem unsure of how to move his/her	body (is clumsy and awkward)	
	SENSORY PROCESSING any statements that describe your child.		
difficulty with transitions/changes	poor frustration tolerance	impulsive	
overly emotional/sensitive	unwilling to try new activities	poor attention	
difficulty calming from tantrums	difficulty sleeping through the night	aggressive	
difficulty separating	difficulty sitting still	avoids messy play	
frequently bumps into objects and people	complains about having teeth/hair br	ushed	
fearful of playground equipment	fearless on playground equipment		
inappropriate behaviors (explain)			
self-abusive behaviors (explain)			
frequent tantrums/meltdowns (explain)			
SIGNATURE OF PERSON ANSWERING QU	TESTIONS DATE	<u> </u>	
RELATIONSHIP TO PATIENT			





Date

# **Consents and Privacy Acknowledgment**

 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.
 <b>Consent for Student Observation:</b> 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.
ture of Child's Parent/Legal Guardian Printed Name