New Patient History & Intake
Pediatric Speech, Occupational & Physical Therapy

General Information

Today's Date: _____ Child's Date of Birth: _____
Child's Name: _____ Gender: ☐ M ☐ F
Referring Physician: _____ Phone #: _____
Primary Care Physician (*if different from above*): _____ Phone #: _____
Parent(s) or Caregiver's Name(s): _____
Address: _____
Home Phone #: _____ Mobile Phone #: _____
Work Phone #: _____ Email Address: _____
Can we leave messages regarding appointments on your home and mobile phone(s)? ☐ Yes ☐ No
Please describe your concerns about your child's development: _____
_____
Is your child attending school/daycare? ☐ Yes ☐ No; If Yes, where? _____
Teacher's name? _____ Phone #: _____
Grade level? ____ Classroom type? _____ Resource room? ☐ Yes ☐ No ESL class? ☐ Yes ☐ No
Resource room and/or ESL classroom teacher's name? _____ Phone #: _____
Does your child receive any services through school? ☐ Yes ☐ No; If Yes, what services? _____
Therapist's name? _____ Phone #: _____
Does your child have a current Individualized Education Plan (IEP)? ☐ Yes ☐ No;
If Yes, when and where is the next IEP meeting? _____

If you checked YES and your child is covered by SC Medicaid or Tricare, please provide a copy of your child's IEP before the evaluation takes place which is required for Medicaid Prior Authorization

Please indicate other diagnoses your child has received:

Diagnosis	Approximate Date of Diagnosis

Family Background

Is your child an adopted or foster child? ☐ Yes ☐ No
If Yes, how old was your child when he/she came into your home? _____ Place of birth:_____
Who lives in your home?

Name	Relationship	Age

With whom does the child spend the most time? _____
Language(s) spoken in the home? _____ Primary language? _____

Is there a family history (parents, siblings, extended family) of any of the following?

☐ hearing loss ☐ cleft palate ☐ speech problem ☐ seizure disorder
☐ prematurity ☐ mental illness ☐ language delay ☐ alcoholism
☐ drug use ☐ ADD/ADHD ☐ reading or learning difficulties

Prenatal and Birth History

☐ Full Term ☐ Premature __ wks ☐ C-section ☐ Vaginal Birth Birth Weight: _____ Length: _____
How long was your child in the hospital following his/her birth? _____ If longer than average, please describe any complications with the pregnancy or delivery: _____
_____

Was your child intubated? ☐ Yes ☐ No; If Yes, please describe how long your child was intubated and on a ventilator as well as other respiratory support such as CPAP, nasal canula, etc.: _____
_____

During pregnancy did the mother experience (mark all that apply)?

☐ hemorrhaging ☐ drug use ☐ alcohol use
☐ smoking ☐ diabetes ☐ high blood pressure
☐ elevated lead levels ☐ hospitalization (explain) _____

Medical History

Mark any of the following that apply to your child:

☐ chronic illness ☐ chronic infections ☐ allergies ☐ lung/bronchial issues
☐ hospitalizations ☐ sight problems ☐ hearing problems ☐ heart defect
☐ sleeping problems ☐ difficulty sleeping ☐ difficulty eating ☐ diabetes
☐ ear infections ☐ seizures ☐ measles ☐ tuberculosis
☐ meningitis ☐ chicken pox ☐ high fever ☐ physical injuries
☐ mumps ☐ whooping cough ☐ other: _____

Please list any other illnesses (other than typical childhood illnesses), hospitalizations, surgeries, and diagnostic testing your child has had: _____
_____

Please list other physicians and specialists who provide care to your child:

Name/Location	Specialty	Phone Number

Current Medications:

Name	Dosage	Frequency	Reason for Medication

Any known allergies? ☐ Yes ☐ No; If Yes, please list: _____
Is your child on a special diet? ☐ Yes ☐ No; If Yes, please describe: _____

What is your child's current weight? _____ pounds _____ percentile
What is your child's current height? _____ inches _____ percentile
Vision tested? ☐ Yes ☐ No; If Yes, date of last vision test: _____
Vision tested by: _____ Results of vision test: _____
Hearing tested? ☐ Yes ☐ No; If Yes, date of last hearing test: _____
Hearing tested by: _____ Results of hearing test: _____
History of recurrent ear infections? ☐ Yes ☐ No; PE tubes placed? ☐ Yes ☐ No;
If Yes, which ear? ☐ Right ☐ Left ☐ Both
If yes, date last PE tubes were inserted: _____ Tubes placed by: _____
Does your child use any adaptive equipment (glasses, hearing aids, etc.)? ☐ Yes ☐ No;
If Yes, list: _____

Developmental History
Please list in years and/or months when the following first occurred:

Held head up _____	Cruise _____	Drink from a cup _____	Skip _____
Rolled _____	Walk _____	Chew meat _____	Scribble _____
Sat alone _____	Smile _____	Fingerfeed _____	Potty trained _____
Stood alone _____	Babble _____	Use a spoon _____	Run _____
Crawl _____	Say first word _____	List first word(s): _____	
Pull up _____	Say first phrase _____	List first phrase(s): _____	

Was there anything irregular about your baby's movements (e.g., skipped crawling, dragged one leg, etc.):
☐ Yes ☐ No; If Yes, please describe: _____

Can your child dress him/herself?	☐ Yes ☐ No
Does your child fall frequently?	☐ Yes ☐ No
Does your child play well with others?	☐ Yes ☐ No
Would you describe your child as "overly active"? Destructive?	☐ Yes ☐ No
Is your child sensitive to touch? Loud noise?	☐ Yes ☐ No
Does your child have unusual sleeping patterns?	☐ Yes ☐ No
Is your child extremely shy? Nervous?	☐ Yes ☐ No
Does your child throw excessive tantrums?	☐ Yes ☐ No
Does your child prefer to play with older or younger children? Adults only?	☐ Yes ☐ No

What is the average amount of time your child can spend on one activity? _____
Please describe your child's favorite activities: _____
_____
Handedness: ☐ Left ☐ Right ☐ Undetermined

Please check the types of play your child engages in most often:

___ throwing and shaking toys	___ games with rules	___ rough and tumble play	___ make believe play
___ banging toys together	___ mouthing toys	___ pushing/pulling toys	___ looking at books

Oral Habits and Feeding
Was your child ☐ breast-fed? (Until what age? _____) ☐ bottle-fed? ☐ combination?
Does your child use a pacifier or suck thumb? ☐ Yes ☐ No; If Yes, how often: _____
Does your child use a bottle? ☐ Yes ☐ No; If Yes, how many bottles per day? _____
If applicable, how old was your child when he/she discontinued use of:

Pacifier? _____ Bottle? _____ Thumb sucking? _____
Would you describe your child as a "mouth breather?" ☐ Yes ☐ No
Do you notice excessive drooling? ☐ Yes ☐ No; If Yes, explain _____
Do you notice excessive mouthing of toys/objects? ☐ Yes ☐ No; If Yes, explain _____
Would you describe your child as a "picky eater"? ☐ Yes ☐ No
Mark any of the following that you have observed:
☐ putting too much food in mouth at one time ☐ food falling out of mouth
☐ unable to drink without spilling ☐ difficulty chewing meats
☐ coughing or choking on certain foods (list) _____
☐ avoiding certain consistencies (list) _____
Please describe a typical meal: _____
At what age were solids introduced? _____ What kind of cup does your child typically drink from? _____

Therapy Information
Is your child currently enrolled in First Steps (BabyNet)? ☐ Yes ☐ No; If Yes, which county? _____
Service Coordinator/Early interventionist's Name? _____ Phone #: _____

Please list other therapies your child is receiving:

Type of Therapy	Frequency	Location	Name of therapist	Therapist Phone #

When was the last evaluation or re-evaluation that your child received for:
Speech therapy: _____; Occupational therapy _____; Physical therapy _____

Please include any information not included on this form you would like to share: _____
_____
_____
_____

Thank you for taking the time to fill this form out completely. Please sign or type name below and either submit electronically or print and bring to your evaluation.

Signature:_____ Relationship:_____

Date: _____

Consent to Bill & Release Protected Health Information

I authorize Lowcountry Therapy Center, LLC to release information necessary for billing my insurance company. If referral(s) is required, I understand that obtaining the referral(s) and keeping track of expiration dates and visit limits is solely my responsibility. It is also my responsibility to provide an IEP – to be shared with the health insurance company only – if needed for reimbursement purposes.

The Benefit Verification Form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. I understand that a referral from my primary care physician is not a guarantee of payment by my insurance company. I assume responsibility for payment of services if denied by my insurance company. I will pay my co-payment at the time of service. I understand that **any fees not paid by my insurance company will be billed to me**.

I understand that evaluations consist of an initial consultation, testing as appropriate and narrative report. Some insurance plans cover only the testing. If this is the case with my insurance, I understand that I am responsible for any non-covered service provided in addition to my co-pay and applicable deductible authorized by my insurance company. Any balance outstanding past 30 days will incur a $25.00 late fee per month.

I understand that I should call at least 24 hours in advance should I need to miss a session. I understand that I can be charged $25.00 for a no-call/no-show missed session.

I understand that if upon retrospective evaluation my insurance company determines that payment was made by them in error or request reimbursement, I will be responsible for said reimbursement.

Please ask questions regarding your insurance policy and payments expected so there are no "surprises." Lowcountry Therapy Center offers free financial counseling upon recommendation of therapeutic services.

Insurance Information

Primary Insurance: _____ Primary Insured's Date of Birth:_____

Managed Care Organization (Medicaid): _____

Name of Policy Holder: _____ Date of Birth: _____

Sponsor Social Security Number (Tricare): _____

It is okay for Lowcountry Therapy Center to leave a message with Protected Health Information (including child's name and dates/times of appointments) on my:

☐ Home Phone ☐ Mobile Phone ☐ Email Address ☐ Other: _____

I have read and understand this Consent to Bill and Release Protected Health Information Statement:

Signature: _____ Date: _____

Pediatric Attendance and Discharge Policies

In order for our therapists to aid in the progress of your child's development, it is important that your child attend all therapy sessions as scheduled and on time. In order to better serve our patients, we have developed the following guidelines.

1. Duration of treatment is an important component of the therapeutic process. Patients are given a prescribed amount of time and are to arrive at the scheduled therapy time every session. If the patient is more than 15 minutes late, the session will be considered a cancelled visit and initiation of therapy will be at the therapist's discretion. **If a patient is more than 15 minutes late three consecutive times, the therapist has the right to discharge the patient.**

It also equally as important to pick your child up on time. If a caregiver is habitually late picking up their child, the therapist is unable to communicate the Home Exercise Program to the caregiver. Furthermore, the team members at Lowcountry Therapy Center cannot be responsible for watching your child outside of therapy times. **If a patient picked up late more than three times, the therapist has the right to discharge the patient.**

2. Frequency of treatment is also an important component of the therapeutic process. Patients are given a prescribed number of days per week based on the findings of their initial evaluation. **We require a minimum of 75% attendance of scheduled sessions per month. The patient may be discharged from the program if this frequency is not met** (e.g., therapy scheduled once a week = one cancellation per month permitted; therapy scheduled twice a week = two cancellations per month permitted, etc.).

3. It is your responsibility to notify the patient care coordinator or therapist if you need to cancel **24 hours in advance of the cancellation**. We are aware that unforeseen events occur that may prevent the 24 hour cancellation; however, please call to cancel. If you do not call to cancel 24 hours in advance, we retain the right to charge a $50 "no cancellation" fee.

4. **If your child is ill, please cancel the therapy session.** Illnesses include - but are not limited to - a fever greater than 99.6°F within a 24 hour period, respiratory (e.g., cough, difficulty breathing) and gastrointestinal symptoms (e.g., vomiting, diarrhea) within a 24 hour period, symptoms of communicable disease (e.g., sniffles, reddened eyes), and/or uncontrolled seizures.

5. If a patient does not show and does not call to cancel, it is considered a "no call, no show." **If there are two "no call, no shows" within a 3 month period then that timeslot is opened up to those on the waiting list. The family will be given the option of being placed on our "on-call list" where it is the family's responsibility to call us to schedule weekly therapy appointments.**

I have read and understand Lowcountry Therapy Center, LLC's Privacy Policy and Attendance Policy:

Signature: _____ Date: _____

Waiver of Liability

I give permission for my child to participate in Lowcountry Therapy Center, LLC's programs and services. I hereby release Lowcountry Therapy Center, LLC principal owners, therapists, employees and representatives and all other individuals or organizations acting on behalf of Lowcountry Therapy Center, LLC program, from any and all claims which I or my child may have, resulting from or in connection with my child's participation in Lowcountry Therapy Center, LLC programs. This includes, but without limitation, any claim, demands or causes of action for injuries to my child, including but not limited to injuries resulting from the use of any play/therapy equipment during the program at the Lowcountry Therapy Center, LLC center or at clients' homes.

I understand that I should be present at all times during delivery of service to my child. If I choose not to, I understand that the aforementioned statements still apply in my presence or absence during the services provided. This agreement is signed for the purpose of fully and completely releasing, discharging and indemnifying Lowcountry Therapy Center, LLC in connection with their programs from all liability as herein described.

I have read and understand Lowcountry Therapy Center, LLC's Waiver of Liability:

Signature: _____ Date: _____

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Lowcountry therapy Center, LLC. In addition, I hereby consent to the use and disclosure of my child's personal health information for the purposes of treatment, payment, and health care operations. I understand that Lowcountry Therapy Center, LLC also serves as a training and research facility and at times other therapists may be observing, handling, or have access to my child's medical information. I authorize Lowcountry Therapy Center, LLC to obtain medical records and/or professional information from my child's physician or other medical professional as it relates to my child's treatment.

I have read and understand Lowcountry Therapy Center, LLC's Notice of Privacy Practices:

Signature: _____ Date: _____