Total Rehab Kids

Patient Registration **Date:** ____________

Patient Information

Name: ______________________ Gender:___M ___F Date of Birth:__________ SSN: ____________

Physical Address: ____________________________ City:_______________ State: _____ Zip:__________

Mailing Address (if different): ______________________ City: ____________State:_____ Zip: __________

Parent or Legal Guardian:________________________________ Relationship: ______________________

Parent Marital Status: ___Married ___Divorced ___Single

Parent Employer _________________________

Home Phone: __________________ Cell Phone: ___________________ Work Phone: _______________

Email:____________________________

Child lives with (name):_____________________________ Relationship: ___________________

- ***Emergency Contact***

Last Name: ______________________ First Name: ______________ Phone:_______________

Relationship: _____________________

- ***Insurance Information***

Does child have Healthcare coverage through a parents employer? ___Yes ___No
(Please be sure to list all coverage below)

Primary

Insurance:_____________________________
ID#: ____________________
Group#:_________________

Subscriber

Name (if different than patient):__________________
Relationship:________________
Date of Birth:________________

Secondary

Insurance:______________________________
ID#:_________________
Group#:______________

Subscriber

Name(if different than patient):____________________
Relationship:_______________
Date of Birth:_______________

Total Rehab Kids

Total Rehab Kids Harlingen is committed to providing quality care while maximizing the outcome of your child's treatment goals. In order to provide you with the best possible care, your child's attendance must be consistent. Each child recieves one on one therapy; therefore, it is our policy that your child must attend all of his/her appointments **on time** in order to adhere to the treatment plan that has been set by the therapist and doctor. Parent / Legal guardian / or other authorized adult must remain in the clinic while your child is receiving services. If you must leave we will stop treatment. We do not provide services without an authorized parent or adult present.

What happens if your child is late? Your child's therapy time may be reduced for the amount of time he/she was late or they may not be able to be seen on that day.

If you are unable to keep your appointment, we ask that you call the office at least one hour prior to your appointment to re-schedule.

If your child has 3 consecutive absences, they will be removed from the schedule. Upon returning to therapy, the original appointment time cannot be guaranteed.

Note: If your child is sick or has a fever, please call to reschedule your appointment. Please do not bring your child if he/she is sick.

Total Rehab Kids offers make-up times on Fridays. Please note that these appointments are limited.

Consent for Treatment

I authorize the staff at Total Rehab Kids Harlingen to administer treatment and procedures as deemed appropriate to improve my child's condition. It is recognized that the practice of physical/occupational/speech therapy is not an exact science and, as such, no guarantees have been made about the outcome of therapy. I am advised that I have the right to a full explanation of any treatment or procedure utilized. I understand that I have the right to refuse treatment for my child; but in doing so, I also understand that the desired outcome of my child's treatment program may be affected. Persistant refusal to participate or cooperate in the recommended treatment program may result in my or my dependents discharge from the program.

For automatic appointment reminder service select one option below:

___ Send email appoinment reminders to (email)____________________________
___ Send text message appointment reminders to ____________________ Cell Carrier______________
___ Please do not send appointment reminders.

Patient or Guardian Agreement:

I authorize release of information requested by my insurance plan for payment.
I authorize to receive email/text messages for appointment reminders (if indicated above).
I understand that I am responsible for any balance due.
I agree to comply with the terms and conditions as outlined in the Patient Registration form.
I consent to treatment as authorized by the physician overseeing the treatment plan.

Notice of Privacy Practices:

I hereby acknowledge that I have have been offered a copy of the Notice of Privacy Practices.

Signature of Patient or Guardian: ______________________________ Date ___/___/___

Relationship:___________________________________

TOTAL REHAB KIDS

Pediatric Case History Form

General Information:

Child's Name: ______________________ Date of Birth: ______________________

Patient's Siblings (include names and ages):

____

____

What languages does the child speak? Which is the child's dominant language?

____

____

What languages are spoken in the home? Which is the dominant language spoken in the home?

____

____

With whom does the child spend most of his/her time? ______________________

What language do they speak? ______________________

Describe the child's speech-language problem. ______________________

What are your concerns with his/her developmental skills?______________________

____

How the child does usually communicates? (Gestures, single words, short phrases, sentences)

____

When was their hearing last checked? ______________________

____

When the problem was first noticed? ______________________

____

Has the child been seen by any other specialists (i.e., physicians, audiologists, psychologists, special education teachers, etc.)? If yes, indicate the type of specialist, why the specialist was seen, and when the specialist was seen.

____

____

____

____

____

Is there any significant medical in the family? __________ If yes, explain.

____

____

Do you and/or caregiver have any disabilities that would interfere with you assisting in carrying over treatment activities in the home? _________If yes, please explain:

____

Prenatal and Birth History:

What was the Mother's general health during pregnancy? (illnesses, accidents, medications, etc.).

____

____

Was your child full-term? _______ If no explain: ____

Were there any unusual conditions that may have affected the pregnancy or birth?

____

____

Developmental History:

Provide the approximate age at which the child began to do the following activities:

Crawl: _____________ Sit: _____________ Stand: _____________ Walk: _____________

Feeds self-using utensils: _____________ Dress self: _____________ Undress self: _____________

Manipulates fasteners: _____________ (buttons, zippers, shoelace) Use Toilet: Yes/No **(circle one)**

Drink from a cup: _____________ Brushes Teeth: _____________ Washes hands and face: _____________

Use single words (i.e., no, mom, doggie): ____

Combine words (i.e., me go, daddy shoe): ____

Name simple objects (i.e., dog, car, tree): ____

Use simple questions/sentences: ____

Engage in a conversation: ____

Does the child have difficulty walking, running, picking things up, or any other physical activities?

____

____

Has the child ever had any difficulty with swallowing (i.e., problems with sucking, swallowing, choking, drooling, chewing, etc.)? If yes, describe.

____

____

____

Medical History:

Provide the approximate ages at which the child has suffered the following illnesses and conditions:

Asthma: ______________ Bronchitis: ________________ Chicken Pox: ____________________

Colds: ________________ Cleft Lip/Palate: ______________ Croup: ________________________

Dizziness: _____________ Draining Ear: ________________ Ear Infections: __________________

Encephalitis: ___________ German Measles: ______________ GERD/reflux: __________________

Headaches: ____________ Hearing Loss: _________________ High Fever: ____________________

Influenza (Flu): _________ Mastoiditis: __________________ Measles: _______________________

Meningitis: ____________ Mumps: _____________________ PE (ear) tubes: _________________

Pneumonia: ____________ Seizures: ____________________ Sinusitis: _____________________

Tinnitus: ______________ Tonsillitis: ___________________ Tuberculosis: __________________

Whooping Cough / Pertussis: ______________________________ OTHER: _____________________

Has the child has any surgeries? If yes, what type and when (e.g., tonsillectomy, tube placement, etc.)?

____

____

Describe any major accidents or hospitalizations.

____

____

____

Please list any medications the child is currently taking.

____

____

____

____

____

Have there been any negative reactions to medications? If yes, explain.

____

____

____

Does the child have any allergies to medications, food, etc.? Please provide allergy and type of reaction.

Educational History:

School: ______________________________ Grade: ______________________________

Does the child receive special services at school? If yes, explain.

How does the child interact with others (e.g., shy, aggressive, uncooperative)?

What toys/objects/foods motivate your child?

Please provide any additional information that might be helpful in the evaluation and treatment of the child.

Name of person completing form: ______________________________

Relationship to client: ______________________________