

NAME: _____ **BIRTHDATE:** ____/____/____ **Age:** ____ **Sex** M F

Name of Legal Guardian if patient is minor _____

Primary Phone: () _____ Mobile Home Other _____

Alternative Phone: () _____ Mobile Home Other _____

Email Address: _____

Emergency Contact: _____ () _____

Name

Phone #

Relationship

LANGUAGE _____ **ETHNICITY: (Mark box below)**

Black/African American

Asian/Pacific American

White American

Native American/Alaskan Native

Latina/Latino/Hispanic American

Other _____

REFERRING PHYSICIAN: _____ **PRIMARY CARE PHYSICIAN:** _____

ALLERGIES: (Drug, Seasonal, Latex, or Food related)

NO YES _____

HANDEDNESS: Right Left

REASON FOR THERAPY _____

WHAT ARE YOUR THERAPY GOALS?

TRAVEL RISK SCREENING: Have you or someone you are in contact with traveled out of the country in the last 21 days? NO YES/LOCATION _____.

If YES, Are you or the person you are in contact with experiencing any of the following symptoms:

Bleeding

Diarrhea

Vomiting/Stomach Pain

Joint/Muscle pain

Headache

Rash

Respiratory Symptoms

Temp over 100.4F

Conjunctivitis/Pink eye

Staff only: Referred to PCP _____

MEDICAL HISTORY: (Mark a box if you have had any of these conditions and explain below)

Anxiety/Depression

Fetal Alcohol

Injury Wrist/Hand

Arthritis

Syndrome

Injury Hip/Leg/Knee

Pulmonary Disease

Asperger's or Spectrum Disorder

Hearing loss/Chronic

Injury Foot/Ankle

Seizures

Asthma

Ear Infections

Injury Shoulder

Sensory Processing Disorder

Cancer

Heart Disease

Injury Spinal/Neck

Stroke

Diabetes Mellitus

Impulsive/Inattentive or Aggressive Behavior

Mental illness

Tuberculosis

Eye disease

Injury Head

Nerve/Muscle Disease

Vision Loss

Other (Please List) _____ Explain: _____

Yes, the patient's immunizations are current

No, the patient's immunizations are not current

SURGICAL HISTORY:

Ear Surgery

Eye Surgery

Fracture Surgery

Brain Surgery

Heart Surgery

Small intestine Surgery

Other (Please List) _____ Explain: _____



SOCIAL HISTORY: (Mark a box if you have had any of these conditions and explain below)

Exercise: 1 time per day Few times per week Few times per month Never

The patient lives with: _____

Siblings in the home: _____

Has the patient been exposed to:

Physical/Emotional Abuse Alcohol or Substance Abuse Neglect

Do you have concerns with transportation, housing, or financial? NO YES _____

Are you concerned about your safety or violence at home? NO YES _____

Are you experiencing difficulty coping with the patient's special needs? NO YES

BIRTH HISTORY: (Please mark if relevant & list condition)

Preterm Delivery/delivered at how many weeks gestation: _____

Patient was in Neonatal Intensive Care Unit _____

DEVELOPMENTAL HISTORY:

Please list any concerns regarding the patient's physical, language, social or emotional development (including delays in development, feeding, nutrition, weight gain, difficulty relating to others, problems at school) _____

Does your child have Individual Education Plan with his/her home school district? YES NO

What services are provided from the school district? _____

What School District is your child enrolled in? _____

MEDICATION LIST: (Please provide your complete list of Current Medications)

<u>Medication/Injection</u>	<u>Dosage</u>	<u>Prescribing Physician</u>	<u>Phone Number</u>
_____	_____	_____	() _____
_____	_____	_____	() _____
_____	_____	_____	() _____

SPECIAL NOTICE

Many insurances do not cover services when a child is referred for a delay in normal development or has a diagnosis showing neurological involvement. If your insurance plan does not specifically have a neurodevelopmental benefit (usually covers until age 7), then your regular benefit for therapy may not cover your child's diagnosis.

How to determine if your child's diagnosis will be covered by your regular therapy benefit:

1. If your child has normal function and it was lost due to an injury or illness, your regular therapy benefit may cover.
2. If your child is being referred because of a delay in normal development, such as speech delay (not talking or difficulty with talking) or lack of muscle strength, coordination or balance, then your child's therapy may not be covered under the regular therapy benefit. However, therapy may be covered if your policy has a neurodevelopmental benefit and your child meets the age requirement. This benefit usually requires prior authorization.

St. Luke's will submit all services to your insurance company. Please be aware that you are financially responsible if the services are not covered under your specific plan.

We have provided the following documents for your review: (Copies are available upon your request)

Patient Rights and Responsibilities Consent to Treat

Signature of Patient or Legal Guardian

Relationship to patient

____ / ____ / ____
Date

ADDRESSOGRAPH