Pediatric Therapy & Play Gym

NEW PATIENT INTAKE FORM

Today's Date: _____/_____/_____

Patient Name:		Gender: □ Male □ Female
Date of Birth: / /	Age:	Language Spoken:
Address:		
Home Phone:	Cell/Work Phone:	Email:
Parent/Guardian Name:		
Primary Care Physician:		Phone:
Referring Provider:		Phone:
Emergency Contact Name:	Relationship:	Phone:
School Name:		Grade:
How did you hear about us?		

MEDICAL INFORMATION

Primary Diagnosis:	Secondary Diagnosis:
Prior Surgery and/or Hospitalization: □ YES □ NO	
Date:	Reason:
Date:	Reason:
Date:	Reason:
Date:	Reason:
Date:	Reason:

245 Newtown Road, Suite 102, Plainview, NY 11803
Tel: (516) 802-2518 | Fax: (516) 644-5471 | info@morethanagym.com

Please list all current medications:		
History of Botox Injections □ YES □ NO	Most recent date: / /	Location:
Please check off all that apply:		
□ History of fractures (date and location):		
□ Allergies (please list all):		
□ Seizures (type and medical management):		
□ Shunt	□ G-Tube	
□ Visual impairment (describe):	□ Hearing loss (describe):	
□ Skin condition (describe):		
□ History of dislocation/subluxation (date and location):		
□ Scoliosis: □ Functional □ Structural	Degrees:	
□ Heart problems (describe):		
□ Respiratory problems (describe):		
□ Gastrointestinal problems (describe):		
Please list additional impairments/symptoms that may affect treatment:		
COMMUNICATION		
Is the child verbal? □ YES □ NO	Communication device used? □ YES □ NO	
Does the child have behavioral challenges? □ YES □ NO Are there behavioral strategies being used? □ YES □ NO		
Does the child follow simple commands? □ YES □ NO		

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BIRTH HISTORY			
# of weeks born:	Delivery method:		
Please describe any complications during pregnancy or delivery:			
Please check off milestones achieved:			
□ Rolling	Age:	□ Pull to stand	Age:
□ Sitting	Age:	□ Standing	Age:
□ Crawling	Age:	□ Walking	Age:

CURRENT ADAPTIVE EQUIPMENT

Orthotics:

□ SMO □ AFO □ KAFO □ HKAFO □ Thoracic brace □ Hand/Wrist splint

□ Other:

Assistive Devices:

□ Gait trainer □ Standard walker □ Rolling walker □ Lofstrand crutches □ Axillary crutches □ Single axis cane

□ Quad cane □ Stander □ Adaptive chair □ Wheelchair

□ Other:

Please check off all current therapies:		
□ Physical Therapy	Duration/Frequency:	Location:
□ Occupational Therapy	Duration/Frequency:	Location:
□ Speech/feeding	Duration/Frequency:	Location:
□ ABA	Duration/Frequency:	Location:
□ Vision	Duration/Frequency:	Location:
□ Other	Duration/Frequency:	Location:
□ Other	Duration/Frequency:	Location:

Has the child previously participated in an intensive physical therapy program? □ YES □ NO

Please list the primary concerns and goals anticipated to achieve in physical therapy:

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Who will be financially responsible for this patient's account?		
Name:	Relationship:	Date of Birth:
PRIMARY INSURANCE		
Insurance Company:	ID #:	Group #:
Claims Address:		
Name of Insured:	Relationship:	Date of Birth:
Insured's Address:		
Insured's Phone:		

□ I verify the accuracy of any information given and authorize the release of any medical and demographic information necessary to process any claims. I understand that my insurance company will be sent an itemized bill for each session in accordance to reasonable and customary charges. I agree to assign benefits directly to More Than A Gym, LTD for all therapy services rendered. I also agree to remit any monies sent to me in error from my insurance company for services rendered to More Than A Gym, LTD. I agree to pay for all services rendered should my insurance company deny payment for services rendered, and will be responsible for any deductible, co-insurance or co-payment, to be paid at the time of my visit.

This office communicates quietly and discreetly about your child's session with you in the waiting area. You may choose to request that therapists communicate information regarding your child in another area of the building or another format.

□ I request that information about my child's session be spoken in another form of communication with the therapist.

CANCELLATION/ DISCONTINUANCE FROM SERVICES POLICY
This office requires 24 hour notice for cancellations. Otherwise, you will be charged the full fee of the session. Should you miss three consecutive visits, it will be considered that you are not in compliance with your plan of care, and you may be discharged from this office.

□ I give permission for photographs/videos to be taken of myself or my child for educational, research, to monitor progress and/or marketing purposes.

_____ _____

Signature of Patient/Responsible Party Date

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