Keystone
Pediatric Therapy

Patient Information Form

Keystone Pediatric Therapy PLLC
2720 Virginia Parkway, Suite 300, McKinney TX 75071
(972) 548-1990

PATIENT INFORMATION:

Patient Name: _____ **Sex:** ☐Male ☐ Female
(Last) (First) (Middle)

Nickname: _____ **Child's Social Security #:** _____ **DOB:** _____

Parent/Legal Guardian: _____ **Relationship:** _____ **SS#:** _____

Parent/Legal Guardian: _____ **Relationship:** _____ **SS#:** _____

Address: _____
(Street) (City) (State) (Zip)

Email Address: _____ **Religion:** _____

***Race:** ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐White
☐Hispanic or Latino ☐Native Hawaiian/Other Pacific Islander ☐Other

***Ethnicity: Hispanic/Latino or Alaska Native** ☐Yes ☐No Language(s) Spoken in the Home: _____

*Required by Title 25, Texas Administrative Code, Chapter 1301.19 ©(1-2)

Referred by: _____

Primary Care Physician: _____ **Phone#:** _____

Address: _____

Specialists involved in child's plan of care (neurologist, gastro-enterologist, developmental pediatrician, pulmonologist, etc.)

Name: _____ **Phone#:** _____

Address: _____

Name: _____ **Phone#:** _____

Address: _____

Allergies:

Food / Environmental Allergies? Yes / No If yes, please list here or attach list.

_____

Medication Allergies? Yes / No If yes, please list here or attach list.

_____

Medication Profile (attach list if necessary):

Medication Name	Dose	Frequency

I understand that it is my responsibility to provide updated information to Keystone Pediatric Therapy on any changes in my child's medications and/or allergies. If I fail to provide this information in a timely manner, I hereby release Keystone Pediatric Therapy from and all liability on information that has become inaccurate.

_____ _____
**Parent/Guardian Signature Date

Patient Preference Regarding Communication of Health Information

I. How to Contact

I wish to be contacted in the following manner:

Home Telephone # _____
[ ] OK to leave message with detailed information
[ ] Leave message with call back number only

Work Telephone # _____
[ ] OK to leave message with detailed information
[ ] Leave message with call back number only

Cell Phone # _____
[ ] OK to leave message with detailed information
[ ] Leave message with call back number only

Day Time Phone # _____
[ ] OK to leave message with detailed information
[ ] Leave message with call back number only

Written Communication:

[ ] OK to mail my home address _____
[ ] OK to mail to my work/office address _____
[ ] OK to fax to this number _____
[ ] OK to email (for appointment reminder only) to: _____

II. Who to Contact

I hereby give permission to Keystone Pediatric Therapy to disclose any information related to my child's therapy session(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name	Relationship

[ ] **I do not wish to disclose information with anyone**

III. Permission to Release Child

Your child will not be released to any person(s) whose name does not appear on the form. NO verbal authorizations will be permitted. If names are to be added or deleted to this list, please do so in writing. The staff at Keystone Pediatric Therapy reserves the right to ask any individual to show proper identification. This is for the protection of your child(ren). I hereby give permission to Keystone Pediatric Therapy to release my child, in my absence, to the following list of people:

Same as above [ ] Yes [ ] No

Name	Relationship

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

_____ _____

**Parent/Guardian Signature Date

INSURANCE INFORMATION:

Primary Commercial Insurance (please bring card to visit)

Insured: _____ Social Security #: _____ Date of Birth: _____

Relationship to Child: _____ Home Phone: _____ Work Phone #: _____

Insurance Company: _____

Identification #: _____ Group #: _____

Employer: _____

Employer Address: _____
Street *City* *State* *Zip*

Secondary Commercial Insurance (please bring card to visit)

Insured: _____ Social Security #: _____ Date of Birth: _____

Relationship to Child: _____ Home Phone: _____ Work Phone #: _____

Insurance Company: _____

Identification #: _____ Group #: _____

Employer: _____

Employer Address: _____
Street *City* *State* *Zip*

Medicaid (please bring card to visit)

Name of Plan: _____

Identification #: _____

*** Please note that we must obtain authorization for therapy visits for your child with Medicaid. Each plan requires separate authorization, so when your child changes from one plan to another; therapy will be discontinued until new authorization is received. This process can take a few days to a couple of weeks, dependeng on the timely response from your child's physician and the plan itself.

_____ _____

**Parent/Guardian Signature Date

HEALTH HISTORY:

Accident Information: Is the admission related to an accident? ☐No ☐Yes If yes, please answer the following questions:

Date & Time accident occurred: _____ **Location of accident:** _____

Description of accident: _____

_____

Does your child have any medical conditions related to the following:

Heart	☐No	☐Yes	Bone Joint Injuries	☐No	☐Yes	Cancer	☐No	
Lungs	☐No	☐Yes	Cytomegalovirus (CMV)	☐No	☐Yes	High Blood Pressure	☐No	
Kidneys	☐No	☐Yes	Seizure	☐No	☐Yes	Difficulty Eating	☐No	
Digestive System	☐No	☐Yes	Arthritis	☐No	☐Yes			
Surgery	☐No	☐Yes	Diabetes	☐No	☐Yes			

If yes, please explain: _____

Does your child have any other medical conditions, contagious or otherwise, that we should know about? ☐No ☐Yes

If yes, please explain: _____

Current Weight: _____ **Height:** _____ **Head Circumference:** _____

Has child had <u>unintentional</u> weight gain or loss of more than 5 pounds in the last 12 months? ? ☐No ☐Yes

SURGERIES / PROCEDURES HOSPITALIZATIONS:

Date	Procedure	Physician / Hospital

Has your child ever been in "isolation" during a hospital stay? ☐No ☐Yes

If yes, please explain: _____

Please check the tests below that your child has received or is scheduled for:

TEST	**DATE TESTED**	**REASON FOR TESTING**
☐Auditory Brain Stem Response		
☐Electroencephalogram (EEG) – Brain		
☐Vision Assessment at School		
☐Vision Assessment by Ophthalmologist		
☐Hearing Assessment		
☐ImmunoglobulinE (IgE) Allergy Test		
☐Food Intolerance Test- gluten,lactose,casein		
☐Magnetic Resonance Imaging (MRI)		
☐Genetic Screen		
☐Video Swallow Study		
☐Other:		

Please check "YES" or "NO" for the following statements and complete the "Comments" section after the questions if needed

YES	NO	HEALTH
☐	☐	Child was born before due date; number of weeks premature: _____
☐	☐	Complications during pregnancy and/or after delivery
☐	☐	Child has been treated for a metabolic disease
☐	☐	Child has frequent headaches
☐	☐	Child has history of ear infections
☐	☐	Child has Pressure Equalization (PE) Tubes (how old when placed?_____)
☐	☐	Child has history of upper respiratory infections
☐	☐	Child has sleep problems
☐	☐	Child experiences diarrhea frequently or is often constipated
☐	☐	Child has an extremely limited diet
☐	☐	Child has reflux or history of reflux
☐	☐	Child has recent injury or regression; Date of injury:
☐	☐	Child is considered healthy

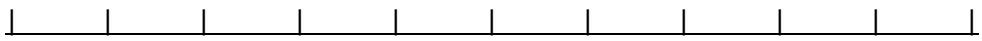
Comments: _____

Pain Assessment:

Is your child having pain/discomfort now or experienced pain recently? ☐No ☐Yes

Please circle the most appropriate number:

0 – 10 Numeric Pain Intensity Scale



0	1	2	3	4	5	6	7	8	9	`10
No Pain		Mild Pain		Moderate Pain		Severe Pain		Very Severe		Worse Possible

CURRENT THERAPY AND EDUCATION INFORMATION:

What is your child's current educational level? _____

Average Grade: ☐A ☐ B ☐C ☐ D Name of School District: _____

Name of School: _____

☐Regular Classroom ☐ Resource Classroom ☐Self-Contained

What Services does your child receive at school? (Include Therapist name and provide Individualized Education Program (IEP) Reports)

Service	Therapist Name	Service	Therapist Name
☐Occupational Therapy		☐Speech Therapy	
☐Physical Therapy		☐Other	

Has your child received therapy services in the past year? ☐No ☐Yes If yes, When and Where? _____

_____

DEVELOPMENTAL HISTORY:

At what ages were the following developmental milestones attained?

Sat at _____ months	Crawled on hands & knees at _____ months	Rode Bicycle without training wheels _____ years
Walked at _____ months	Said 1st meaningful word at _____ months	Completed toilet training at _____ years

Yes	No	Communicating with You
☐	☐	Cries when he/she wants something
☐	☐	Points or gestures when he/she wants something
☐	☐	Makes sounds to try to communicate his/her needs
☐	☐	Uses one-word (1) utterances to communicate
☐	☐	Uses two- to three-word (2-3) utterances to communicate
☐	☐	Uses 3-plus words to communicate
☐	☐	Uses long sentences to communicate
☐	☐	Family understands the child's speech
☐	☐	People outside the family understand the child's speech

Yes	No	Understanding Language
☐	☐	Child understands commonly used spoken words (*i.e., hello, ball, bye)*
☐	☐	Child responds to his/her name
☐	☐	Child focuses on pictures in books
☐	☐	Child points to picture in book upon request
☐	☐	Answers simple "who", "what", "where", and "why" questions
☐	☐	Hears and understands most of what is said at home and school

Yes	No	Eating / Swallowing
☐	☐	Child gags often on certain foods
☐	☐	Child avoids certain textures/types/colors of food
☐	☐	Child has difficulty chewing or swallowing food in a timely manner
☐	☐	Child coughs frequently on food or drink
☐	☐	Child eats age-appropriate foods
☐	☐	Child independently uses all utensils age-appropriate (*i.e. spoon, cup, straw)*
☐	☐	Child measures appropriate weight and height for his/her age

Yes	No	Cognitive Functions
☐	☐	Child independently says or sings familiar rhymes and songs
☐	☐	Child solves most routine problems with minimal assistance
☐	☐	When given the initial prompt, the child remembers situations and events that occurred earlier in the day
☐	☐	Child consistently recognizes familiar toys or people
☐	☐	Child interacts with peers for only a short period or plays side by side with peers
☐	☐	Child remembers location of favorite toy or object after a short period of time
☐	☐	Child requires help in dialing a phone number to place a call
☐	☐	Child answers the telephone and converses

Yes	No	Motor Functions
☐	☐	Child appears clumsy or topples without cause
☐	☐	Child has difficulty grasping a pencil or crayon
☐	☐	Child has difficulty throwing a ball (*and is at least (3) years old)*
☐	☐	Child has difficulty catching a ball (*and is at least (3) years old)*
☐	☐	Child can walk independently
☐	☐	Motor skills are at age level

Yes	No	Tactile
☐	☐	Child objects to tags at the back of neck or clothing
☐	☐	Child avoids getting messy (*i.e. fingerpainting)*
☐	☐	Child avoids wearing shoes or loves to be barefoot
☐	☐	Child reveals distress during grooming activities (*i.e. brushing hair and/or teeth*)
☐	☐	Child has decreased awareness of pain
☐	☐	Child avoids playing in the grass and/or sand

Yes	No	Vestibular Functions
☐	☐	Child gets car sick
☐	☐	Child avoids movement (*i.e. does not allow feet to leave the ground)*
☐	☐	Child tends to stand rather than sit to eat
☐	☐	Child is obsessive about swinging, spinning or bouncing
☐	☐	Child gets dizzy after spinning
☐	☐	Child twirls/spins self frequently throughout the day

Yes	No	Social / Daily Routine
☐	☐	Child has rigid daily routine or an outburst will occur
☐	☐	Child requires medication for behavior control
☐	☐	Child plays appropriately with age level peers
☐	☐	Child plays with toys appropriately for his/her age

Comments regarding language, feeding, cognitive, motor, tactile, vestibular, and social skills answers listed above: _____

What are your concerns regarding your child's abilities? Please be specific as to skills you would like your child to attain as well as differences or difficulties your child is experiencing. (DO NOT LEAVE BLANK)

COMMUNICABLE DISEASE / IMMUNIZATION SCREEN:

Are your child's immunizations up-to-date? ☐Yes ☐No If "No", please contact your primary care physician.

In addition, we need for you to understand that the health and safety of all children and staff must be protected, so please be aware of the following:

1. YOUR CHILD MAY NOT VISIT OR RECEIVE TREATMENT IF THE CHILD HAS ANY OF THE DISEASES / SYMPTOMS LISTED BELOW.	_____ *Initial Here*
2. THESE DISEASES COULD BE HARMFUL TO THE CHILDREN WHO RECEIVE TREATMENT AT KEYSTONE PEDIATRIC THERAPY PLLC	_____ *Initial Here*
3. PLEASE LET THE STAFF KNOW IF YOUR CHILD IS EXPOSED TO OR BECOMES ILL WITH ANY OF DISEASES/SYMPTOMS LISTED BELOW.	_____ *Initial Here*

Has your child been exposed to ANY of these communicable diseases or had any of the symptoms TODAY or IN THE LAST 24 HOURS?

Diarrhea	☐No	☐Yes	Cold Sores	☐No	☐Yes
Nausea and Vomiting	☐No	☐Yes	Impetigo	☐No	☐Yes
Fever	☐No	☐Yes	Infected or Draining Sores	☐No	☐Yes
Cough	☐No	☐Yes	Rash from Unknown Cause	☐No	☐Yes
Running Nose	☐No	☐Yes	Pink Eye	☐No	☐Yes
Sore Throat	☐No	☐Yes	Night Sweats, Fever, Weight Loss, Coughing up blood	☐No	☐Yes
Measles	☐No	☐Yes	Chicken Pox	☐No	☐Yes
Mumps	☐No	☐Yes	Tuberculosis	☐No	☐Yes
MRSA (methicillin-resistant staphylococcus aurea	☐No	☐Yes			

By signing below, I certify that I have answered all questions with accurate and complete information. I understand that it is my responsibility to promptly notify Keystone Pediatric Therapy if I discover any information is or becomes inaccurate or incomplete. I hereby release Keystone Pediatric Therapy from all liability for any action based on inaccurate or incomplete information both now and in the future that I have failed to notify Keystone Pediatric Therapy about.

** Parent or Guardian Signature	Date	Time

Staff Signature	Initials	Date	Time

Staff Signature	Initials	Date	Time

Staff Signature	Initials	Date	Time