CHAYAH
PEDIATRIC THERAPY
T. 832.490.8488 • F. 713.456.2041 • 17117 Westheimer Rd Ste 22, Houston TX 77082

Child's name: _____ DOB: _____ Age: _____ (M) (F)
Current Diagnosis: _____
Home Address: _____ City: _____ Zip: _____
School Attendance History: _____ Grade: _____

Parent/Guardian #1 name: _____ Occupation: _____
Relationship to Child: _____ Custody Status: _____
Home Address (if different from above): _____
Preferred Phone Number: _____ Home/Work/Cell Email: _____

Parent/Guardian #2 name: _____ Occupation: _____
Relationship to Child: _____ Custody Status: _____
Home Address (if different from above): _____
Preferred Phone Number: _____ Home/Work/Cell Email: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Language: _____ Language Spoken at Home: _____
Child's Primary Physician: _____ Address/Phone: _____
Child's Referring Physician: _____ Address/Phone: _____
Reason for Referral: _____

Is there a joint-custody or parenting plan in effect? ☐ Yes ☐ No
Is there a restraining order in effect? ☐ Yes ☐ No
Is the restraining order against: ☐ Mother ☐ Father ☐ Other: _____

What are your primary areas of concern/What are you hoping for the therapist to address?

_____
_____
_____
_____

What are your goals for therapy?

_____
_____
_____
_____

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Does your child ever complain of pain? If so, in what area? Please describe:

Please list any medical precautions/allergies/medications:

Is your child receiving any other services? (i.e. Speech Therapy, Physical Therapy, Occupational Therapy, Special Education, Early Intervention)

What (if any) special equipment does your child use?

☐ Wheelchair ☐ Braces ☐ Communication Device
☐ Eye glasses ☐ Walker ☐ Other:
☐ Hearing Aids ☐ Crutches

Please list any significant prenatal or birth history:

☐ Premature (Gestation: _____weeks)
☐ Full Term
☐ Low Birth weight (_____lbs)
☐ Breech Birth
☐ C-section Birth (Planned)
☐ Emergency C-Section
☐ Vaginal Birth
☐ Forceps Delivery
☐ Vacuum Delivery
☐ Preeclampsia
☐ Gestational Diabetes
☐ Breast Fed
☐ Poor suction/latch
☐ Bottle Fed
☐ Multiple Ultrasounds
☐ Oxygen at Birth
☐ NICU Stay (Duration in NCIU: _____)
☐ Other:_____

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Medical History

Please list any significant illness, hospitalizations, etc.:

_____

_____

_____

_____

- ☐ Chronic ear infections
- ☐ Tubes
- ☐ Tonsils/Adenoid Surgery
- ☐ Reflux
- ☐ Surgeries (list above)
- ☐ Poor weight gain
- ☐ Colic
- ☐ Poor Sleep
- ☐ Asthma
- ☐ Lyme Disease
- ☐ Abnormal Muscle Tone
- ☐ Torticollis
- ☐ Frequent Antibiotic Use
- ☐ Frequent Fevers
- ☐ Compromised Immune System
- ☐ Abnormal Lab Results
- ☐ Cardiac Issues
- ☐ Other:_____

Developmental History

Fill in the blanks to describe your child to the best of your ability:

- Sat at _____months/years
- Crawled at _____months/years
- Stood at _____months/years
- Walked at _____months/years
- Ran at _____months/years
- Dressed at _____months/years
- Toilet trained at _____months/years
- Fed self at _____months/years
- First single words at _____months/years
- Put words together at _____months/years
- Making sentences at _____months/years

Please list any motor development concerns you have. (i.e. gross motor, fine motor, oral motor, motor planning, fear of movement, fear of heights, etc.)

_____

_____

Please list any concerns with feeding/eating or allergies.

_____

_____

- ☐ Was placed on his/her belly as an infant
- ☐ Enjoyed belly time as an infant
- ☐ Met all motor milestones on time
- ☐ Is athletic/plays sports
- ☐ Is good negotiating playground equipment
- ☐ Is good with his/her hands (fine motor skills)
- ☐ Was not placed on his/her belly as an infant
- ☐ Did not tolerate being placed on his/her belly as an infant
- ☐ Was late to:_____
- ☐ Was/is developmentally delayed
- ☐ Is clumsy
- ☐ Avoids climbing, swinging, sliding
- ☐ Gets overwhelmed in public places

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Speech/Language Development

What is your child's primary mode of communication? (Gestures, signing, single words, short phrases, sentences, augmentative device, picture exchange. etc)

How does your child get his/ her needs met? (Pointing, grunting, taking item to you, requesting verbally, etc.)

Please give an estimate of how many words are in your child's vocabulary:

Receptive (words understood):_____

Expressive (words spoken):_____

How much of your child's speech do you understand?

☐ 10% or less ☐ 11-24% ☐ 25-50% ☐ 51-74% ☐ 75-100%

Are there any sounds your child has difficulty with? Please list:

How much of your child's speech do others understand?

☐ 10% or less ☐ 11-24% ☐ 25-50% ☐ 51-74% ☐ 75-100%

Does your child demonstrate frustration when he/she is not understood? If yes, please explain.

Is your child able to follow directions? (1 and 2 step?)

Has your child's hearing been checked recently? Yes/No Results:_____

Any concerns with hearing?

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Academic History

Please check all that apply to your child:

- ☐ Does well in school
  Does well in the area of: _____
- ☐ Is challenged by school
  Average grades: **A B C D F**
- ☐ Is in a self-contained classroom
- ☐ Is receiving school-based services.
  List services: _____

List any academic concerns you have:

_____

_____

List any specific teacher concerns:

_____

_____

Behavior/Social History

Please check all that apply to your child:

- ☐ Is social and engaging
- ☐ Makes good eye-contact with adults and peers
- ☐ Is well behaved
- ☐ Pays attention
- ☐ Listens well
- ☐ Follows directions well _____ 1 step
  _____ 2 step
- ☐ Plays well with other children
- ☐ Is easy going
- ☐ Does well with change
- ☐ Understands safety
- ☐ Takes turns with peers
- ☐ Recalls and tells about everyday events
- ☐ Maintains topic
- ☐ Is aggressive
- ☐ Is oppositional
- ☐ Does not like new places/people
- ☐ Does not like crowds
- ☐ Has difficulty with transitions
- ☐ Prefers to play alone
- ☐ Has difficulty paying attention
- ☐ Has difficulty listening
- ☐ Is very busy and active
- ☐ Poor coping skills
- ☐ Unable to self-calm
- ☐ Extremely sensitive to criticism
- ☐ Quickly escalates without apparent cause
- ☐ Has tantrums

Please list any behavioral or social concerns:

_____

_____

What are some of your child's favorite toys/interests?

_____

_____

_____

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Evaluation & Therapy Services

Please list any previous therapy evaluations complete and recommendations:

Please list any previous psychological/neurophysological/psych-educational evaluations completed and recommendations:

Authorization for Treatment

My signature below is confirmation that I have informed Capstone Physical Therapy of all necessary information and have answered all questions truthfully and to the best of my ability. I authorize the therapists of Capstone Physical Therapy to administer such treatment as is prescribed and considered therapeutically necessary on the basis of findings during the course of treatment.

Parent Signature _____ Date _____

Insurance Information • Please present your insurance card to the front desk for scanning.

Primary Insurance _____ Subscribers Name _____
DOB ___/___/___ ID Number _____ Group Number _____
Secondary Insurance _____ Subscribers Name _____
DOB ___/___/___ ID Number _____ Group Number _____

I hereby authorize my insurance benefits to be paid directly to the provider of these services. I am financially responsible for any balance due, including services that are not covered by my insurance plan. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. A photocopy of this document is considered as valid as the original. If appointments are cancelled with less than 24 hour notice there is a $30 cancellation fee that will be the patients responsibility.

Parent Signature _____ Date _____