Movement to Wholeness LLC

PEDIATRIC NEW CLIENT FORM

FAMILY INFORMATION

Child's Full Name: _____ **Nickname:** _____

Date of Birth: _____ **Age:** _____ **Sex:** ____ **Blog:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Parent's Marital Status ❑ Never Married ❑ Married ❑ Separated/Divorced

Father's Name: _____	Mother's Name: _____
DOB: _____	DOB: _____
Address: _____	Address (if different) _____
City/State/Zip: _____	City/State/Zip: _____
Home telephone: _____	Home telephone: _____
Work telephone: _____	Work telephone: _____
Cell Phone: _____	Cell Phone: _____
Email: _____	Email: _____
Employer: _____	Employer: _____
Position: _____	Position: _____
Primary language: _____	Primary language: _____
Parental status ❑ Birth ❑ Foster ❑ Adoptive	Parental status ❑ Birth ❑ Foster ❑ Adoptive

Please List Names and Ages of All Other People Living in the Home:

Name	Age	Relationship	Primary language	Secondary language
_____	____	_____	_____	_____

_____ ____ _____ _____ _____

_____ ____ _____ _____ _____

_____ ____ _____ _____ _____

_____ ____ _____ _____ _____

Reason for visit: _____

_____

_____

Source of referral: ❑ Word of Mouth ❑ Internet ❑ Support Group ❑ Physician
❑ ABM Directory ❑ Feldenkrais Directory ❑ Other

If "Other", please explain: _____

_____

BIRTH HISTORY

Pregnancy: ❑ Normal ❑ Complications (please explain briefly) _____

_____

Labor: ❑ Spontaneous ❑ Induced ❑ Premature ❑ Complicated (please explain briefly)

_____

Anesthesia: ❑ None ❑ Epidural ❑ Spinal ❑ Other (please explain briefly)

_____

Delivery: ❑ Cesarean ❑ Vaginal ❑ Breech ❑ VBAC ❑ Forceps ❑ Vacuum

Single Birth: ❑ Yes **Multiple Birth:** ❑ Twins ❑ Triplets ❑ Other _____

Gestational Age: ____ weeks **Birth Weight:** ____ lbs. ____ oz./grams

Apgar Score: _____ at 1 min. _____ at 5 min. _____ at 10 min.

NICU: ❑ No ❑ Yes _____ days _____ weeks ____ months

Other complications: _____

_____

RELEVANT MEDICAL HISTORY

Illnesses, Injuries, Surgeries, & Hospitalizations since birth: (Check all that apply)

❑ Meningitis	❑ Hernia repair	❑ VP shunt
❑ Head injury	❑ PDA repair	❑ Tracheostomy
❑ Bone fracture	❑ Circumcision	❑ Frequent ear infections
❑ Encephalitis	❑ G-tube insertion	❑ Failure to thrive

Other: _____

Digestion: Frequency of bowel movements: ❑ More than once daily ❑ Once daily ❑ Once in 2 days

❑ Identified problem of chronic constipation ❑ Frequent diarrhea

Medications: _____

Supplements: _____

Allergies: _____

Immunizations: ❑ Regular Schedule ❑ Altered Schedule ❑ Other (Explain) _____

_____

Medical Diagnoses with which your child has been labeled:

❑ Cerebral Palsy	❑ Seizure Disorder
❑ Hypotonia	❑ Autism Spectrum Disorder
❑ Developmental Delay	❑ Chromosomal Abnormality

❑ Other (Describe) _____

Pediatrician / Family Physician:

Name: _____

Address: _____

Telephone: _____ Fax: _____

Neurological Evaluation:

Date & Results (including MRI's): _____

_____

Neurologist Name: _____

Address: _____

Telephone: _____

Orthopedic Evaluation:

Date & Results: _____

_____

Orthopedist Name: _____

Address: _____

Telephone: _____

Vision Test:

Date & Results: _____

_____

Ophthalmologist Name: _____

Address: _____

Telephone: _____

Optometrist Name: _____

Address: _____

Telephone: _____

Hearing Test:

Date & Results: _____

_____

Previous Therapy Interventions:

County-Based Early Intervention: ❑ PT ❑ OT ❑ ST ❑ Other (explain): _____

_____

School-Based: ❑ PT ❑ OT ❑ ST ❑ Other (explain): _____

_____

Private Therapy: ❑ PT ❑ OT ❑ ST ❑ Other (explain): _____

_____

Other Physicians and Surgeons involved in child's care with address & telephone:

_____

_____

_____

Complementary or Alternative Healthcare Professionals Consulted

(Check all that apply and provide name, address, and telephone of each)

❑ Osteopath _____ ❑ Craniosacral Therapy ❑ Nutritionist _____

_____ _____ _____

_____ _____ _____

❑ Chiropractor _____ ❑ Homeopathy _____ ❑ Massage _____

_____ _____ _____

_____ _____ _____

❑ Feldenkrais _____ ❑ Other _____

_____ _____

_____ _____

DEVELOPMENTAL HISTORY

(Please note approximate age in months for each)

Rolled Over: _____ stomach to back _____ back to stomach _____ for locomotion

Sitting: _____ stayed sitting when placed _____ got self into sitting position

Crawling: _____ on belly _____ rocking on hands & knees _____ creeping on hands & knees

Standing: _____ held weight _____ stayed up when placed _____ pulled self up to stand

Walking: _____ stepping with hands held _____ cruising around furniture _____ steps without support

_____ walking independently more than 10 steps

Walking on toes: ❑ Never ❑ Rarely ❑ Occasionally ❑ Frequently

Jumping: _____ in place _____ over a line _____ off of step (_____ height) _____ over obstacles

Hopping 3 or more times: _____ on right foot _____ on left foot

Falls: ❑ Never ❑ Rarely ❑ Occasionally ❑ Frequently

Baby Devices Used: (age in months & estimated hours per day)

❑ Sling _____ ❑ Swing _____ ❑ Exersaucer _____ ❑ High Chair _____

❑ Johnny Jump-up _____ ❑ Pac'n Play _____ ❑ Bumpo or other sitter _____

❑ Other (describe) _____

Manipulation (age in months)**:** Hands to mouth _____ holding objects _____ holding object in both hands simultaneously _____ banging two objects together _____ manipulating toys like pop beads or shape sorters _____ scribbling _____ participating in dressing _____ dressing oneself _____ holding bottle _____ feeding oneself using fingers _____ feeding oneself using utensils _____

Toileting (age in months): urinating or defecating in toilet when placed there _____ initiating use of toilet _____ reliably uses toilet _____ stopped wearing diapers _____

Communication (age in months)**:** looks at caregiver _____ smiles _____ cooing &/or babbling _____ gestures bye-bye _____ uses 5 words _____ speaks in sentences _____

Feeding: Breast-feeding _____ bottle feeding _____ puree _____ coarsely ground food _____ Cut-up table food _____

Favorite Toys: _____

Favorite Activities &/or Positions: _____

Response to Music or Singing: _____

INSURANCE INFORMATION (From insurance card. * all fields required.)

*Primary Insurance Company: _____

*Insurance Type: ❑ PPO ❑ POS ❑ HMO ❑ Other _____

*Claims Address: _____

*Claims Phone: _____

Clearinghouse ID Number (to be completed by provider): _____

*Policy Holder/Guarantor: _____

Relationship to Client: ❑ Parent ❑ Grandparent ❑ Other _____

*Policy Number/Member ID: _____

*Group Plan Number: _____ *Policy Name: _____

*Effective Date of Plan: _____ *Co-Pay or Co-Insurance: _____

*Annual Deductible: _____ Amount of Deductible Already Paid: _____

*Restrictions/Limits of Plan: _____

*Out-of-Network coverage for Physical Therapy _____

Policy Holder Information:

Name: _____

Address: _____

City _____ State _____ Zip Code: _____

Email Address: _____ Home Phone: _____

Cell phone: _____ Work phone: _____

Social Security No. of Policy Holder: _____

Date of Birth of Policy Holder: _____ Gender of Policy Holder: ❑ M ❑ F

If you have any Secondary Insurance, please provide that information here: _____

_____

_____