1725 HERMITAGE BLVD., TALLAHASSEE, FL 32308

PATIENT HEALTH QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS AS THOROUGHLY AS POSSIBLE SO WE HAVE A BETTER UNDERSTANDING OF YOUR CHILD'S NEEDS.

TODAY'S DATE: _____

PATIENT CONTACT INFORMATION

CHILD'S NAME: _____ **GENDER:** MALE / FEMALE (circle one)

DOB: _____ **AGE:** _____

PARENT(S)/GUARDIAN(S) NAME:

_____

ADDRESS:

_____

_____

_____

CONTACT INFORMATION:

HOME (_____)_____ **WORK** (_____)_____

CELL (_____)_____

EMAIL _____

PLEASE LIST AN ALTERNATE EMERGENCY CONTACT:

_____

ALTERNATE CONTACT PHONE NUMBER:

(____)_____

WHAT SHOULD WE DO IN THE EVENT OF AN EMERGENCY?:_____

CHILD'S PRIMARY CARE PHYSICIAN:

_____

HOSPITAL PREFERENCE:

_____

ALLERGIES (EX. FOOD, DRUG, LATEX):

_____

MEDICAL PRECAUTIONS:

_____

PATIENT'S MEDICAL HISTORY

CHILD'S DIAGNOSIS/DIAGNOSES:

_____
_____
_____

HEIGHT: _____ WEIGHT: _____
OTHER SPECIALISTS/PHYSICIANS/THERAPISTS:

_____
_____
_____

DAYCARE OR SCHOOL YOUR CHILD IS ATTENDING:_____
GRADE LEVEL: _____

PREGNANCY / BIRTH HISTORY: (ANY COMPLICATIONS BEFORE BIRTH?)

_____
_____
_____

AT HOW MANY MONTHS GESTATION WAS YOUR CHILD BORN?

_____

WERE THERE ANY COMPLICATIONS AFTER BIRTH?:

_____
_____
_____

PAST MEDICAL HISTORY / SURGERIES / HOSPITALIZATIONS:

_____
_____
_____

MEDICATIONS & REASONS:

_____
_____
_____
_____

RECENT HEARING & VISION SCREEN (Include dates and results)

_____

HOW DOES YOUR CHILD COMMUNICATE? HOW DO YOU COMMUNICATE WITH YOUR CHILD?

_____
_____
_____

DESCRIBE CHILD'S DIET/ EATING HABITS/ FLUID INTAKE/ DIET MODIFICATIONS IF APPLICABLE:

_____
_____

DEVELOPMENTAL MILESTONES (walking, crawling, sitting up, babbling, first words)

_____
_____
_____

WHAT ARE YOUR PRIMARY CONCERNS?

_____
_____
_____

OCCUPATIONAL THERAPY SECTION

FINE MOTOR CONCERNS:

_____

DEVELOPMENTAL CONCERNS:_____

SENSORY CONCERNS: PLEASE CHECK ALL THAT APPLY

- ☐ Dislikes clothing tags/ seams
- ☐ Dislikes being held or touched
- ☐ Becomes anxious when feet leave the ground
- ☐ Withdraws from bright/flashing lights
- ☐ Holds hands over ears to protect from sounds
- ☐ Doesn't like teeth brushing
- ☐ Avoids getting messy
- ☐ Dislikes swings/playground equipment
- ☐ Avoids eye contact
- ☐ Dislikes noisy environments
- ☐ Limited food choices
- ☐ Resists certain textures: (please describe)_____

PHYSICAL THERAPY SECTION

LIST OF MEDICAL EQUIPMENT THAT YOUR CHILD IS USING (Braces, walker, crutches, wheelchair):

_____
_____

CHILD'S ABILITIES (rolling, sitting, crawling, and walking):

_____
_____

SPEECH-LANGUAGE THERAPY SECTION

EAR INFECTIONS / HISTORY OF TUBES (how old and how many?):

_____
_____
_____

FEEDING AND/OR SWALLOWING CONCERNS: (EX: chewing difficulties, choking, coughing while eating, excessive drooling)

_____

PREVIOUS SPEECH – LANGUAGE THERAPY:

_____

FAMILY HISTORY OF SPEECH-LANGUAGE THERAPY:

_____
_____

HOW DOES YOUR CHILD REQUEST DESIRED ITEMS?

_____
_____
_____

PRIMARY CONCERN (EX. pronunciation of sounds, following directions, social interaction):

_____
_____
_____

CANCELLATION CONTRACT
Procedures Form

Name Date

Home phone: Work phone: Cell phones:

The purpose of these procedures is to safeguard our therapists from losing valuable time that could be spent treating clients and to accommodate our kids that are on a waiting list. If a family is not being consistent with their appointments, we need to give others the opportunity to be scheduled.

We understand it's not always possible, especially when your child is sick, but please call ahead to cancel your child's appointment at least 24 hours in advance.

For those patients that do not give at least 24 hour notice or simply do not show three times in a 3 month period, your child will forfeit his/her permanent appointment to a new child. You will be put on the call in list.

I have read and understand the importance of this Patient/Clinic contract. I will abide by the rules and limitations stated above.

Signature Date

DISCLOSURE OF INFORMATION

RECEIVING INFORMATION:
AGENCY: _____PHONE: _____

ADDRESS: _____FAX: _____

Contact Person: _____

DISCLOSING INFORMATION:
AGENCY: _____PHONE: _____

ADDRESS: _____FAX: _____

Contact Person: _____

Patient Name: _____DOB: _____

Records Requested
_____Medical (Diagnosis, Treatment, Prognosis)
_____Audiometric Assessment/Recommendations
_____Physical Therapy Reports
_____Occupational Therapy Reports
_____Speech-Language Assessment Reports/Data
_____Speech-Language Treatment Plans
_____Speech-Language Progress Reports/Data
_____Psychological Assessment Reports
_____Academic Test Scores/Reports/IEPs
_____Other: _____

I authorize the release of the requested information. I understand this is voluntary.
I understand that if the organization authorized to receive or to disclose the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.

I understand that my healthcare and payment of my healthcare will not be affected by my signing this form. I understand I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. I understand this authorization expires in 1 year from the date of this form, I understand I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on any actions taken before they received the revocation.

_____ _____ ___/___/___
Signature Relationship Date

You may refuse to sign this authorization

CONSENT FOR PARTICIPATION/INFORMED CONSENT WAIVER

Progressive Pediatric Therapy Services provides a specialized intensive exercise program for children with developmental, neurological, sensory, mental, orthopedic, and other types of disabilities. As one might expect, there is some element of risk involved with any physical activity/exercise, intense exercise program, and the use of all exercise equipment (including the Therasuit & the Universal Exercise Unit). Although the risk is greatly reduced with the use of safety equipment, proper supervision, training and skilled trainers, there still remains the risk of injury during participation in the center's activities.

Therefore it is necessary to get your permission to allow: _____
(Print child's name)
to participate in the exercise program provided by the Progressive Pediatric Therapy Services.

I, _____ (Parent/Guardian) hereby release the Progressive Pediatric Therapy from any liability, claims, demands, & causes of action, now or in the future, resulting from soreness or injury however caused, occurring during or after my child's participation in the exercise program.

In signing this Consent for Participation/Informed Consent Waiver, I hereby affirm that I have fully read the above statements & understand the inherent risks involved with participation in the Progressive Pediatric Therapy Center's exercise program and give permission for my child to participate.

_____ _____
Parent or Guardian Signature Date

Print Parent or Guardian Name: _____

Address: _____

Phone: _____

ALLERGY QUESTIONNAIRE

NAME: _____ DATE: _____

1. Does your child have other food allergies/sensitivities? _____ Yes (see below) ___ No
Please indicate how these food allergies/sensitivities are handled in your home (example: anaphylaxis - total avoidance: ok as an ingredient or in limited amounts; child able to set limits related to allergy; etc).

_____

_____

Is your child allergic to certain foods such as fruit or nuts?

_____

Does your child have food sensitivities? _____

Has your child ever experienced itching, hives, swelling or symptoms like a runny nose wheezing, eye irritation or difficulty breathing after a:

- Dental exam or procedure
- Contact with a balloon
- An exam by someone wearing gloves

Have you ever been informed by a doctor that you child
Has a latex or rubber gloves allergy? _____

Does your child have any other medical conditions that require dietary modification?
_____ Yes (see below) _____ No

Does your child have celiac disease or gluten intolerance? How long has your child been diagnosed with celiac disease or gluten intolerance? _____

In your opinion, what is your child's level of compliance with the gluten-free diet?
_____100% _____75% _____50% _____25%

Does your child have difficulty following the gluten-free diet if you are not able to monitor or help him/her?
_____ Yes _____ No

What type of symptoms will your child have if he/she has ingests gluten? Will he/she tell someone he/she is sick? _____ Yes _____ No

Photo Release

PPTS will make every attempt to **not** include your child in individual or group pictures without written consent. We routinely use such photos to promote PPTS summer camp, and other activities of PPTS, and request donations for scholarships.

Photo Release: I, _____ give Progressive Pediatric
(Parent's name)

Developmental Center or Progressive Pediatric Therapy Services permission to use my child's photograph for the purposes of recruitment, advertising, public relations, obtaining grants, or other purposes related to the mission and work of PPTS, as well as for the historical records of the organization.

Signature _____ Date _____

Print Name _____

Observation Permission

PPTS will make every attempt to **not** include your child in individual or group observation without written consent. We routinely have student observers or camp tours.

Observation Release: I, _____ give the Progressive Pediatric
(Parent's name)
permission to allow my child to be observed at Progressive Pediatric for the purposes of therapy, teaching, or parent touring of the facilities for the purpose of enrolling their child.

Signature _____ Date _____

Print Name _____

Signature: _____ Date: _____

HIPAA Procedures Form
Health Insurance Portability and Accountability Act.

Name Date

Address City State

Phone Number

Cell Phones: Email:

The purpose of these procedures is to safeguard confidential information and to minimize the risk of unauthorized access, use or disclosure of patient information

Confidentiality is extremely important

- Any documents containing protected health information, personal information, and the patients folders will not be left open or unattended in a public area.
- Any phone conversations held with a patient will be held in a private area, behind closed doors.
- No discussion regarding patients and their personal information will be held in open public areas.
- You will only access and use information necessary to complete an authorized task. No patient folders or copies of patient information will leave this office.
- All information or questions of the parent regarding a patient's therapy sessions should be redirected to a staff member.

I have read and understand the importance HIPPA's patient confidentiality. I will abide by the rules and limitations stated above.

Signature Date

Session and Treatment Accountability

Please be advised that while we do bill insurance, there is no guarantee that insurance will cover your sessions.

In the event that insurance does not cover any remaining costs parents/guardians are responsible for payment for the balance owed.

Please see front office staff for any questions or specific concerns.

I have read and understand the obligation for services rendered.

_____

Signature Date