

Pediatric Patient Registration:

Child's Full Name: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Is the patient a Foster Child? Yes / No

If yes:

Case Worker Name: _____

Email: _____

Phone: _____ County: _____

Additional Information regarding care, contact, and restrictions:

Guardian Information:

Guardian's Name (1): _____

Address (If different from child's): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Guardian's Name (2): _____

Address (If different from child's): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Doctor Information:

Physician/Pediatrician (Name and Facility): _____

Phone Number: _____ Fax Number: _____

Parent/Guardian

Signature: _____ **Date:** _____

By typing your name above you agree that your typed signature can be used as your actual signature.

School History: If your child is in school please answer the following:

Name of school and grade: _____

Has your child repeated a grade: _____

What are your child's strengths and/or best subjects: _____

Is your child having difficulty and/or receiving help with any subjects?

Parent/Guardian

Signature: _____ **Date:** _____

By typing your name above you agree that your typed signature can be used as your actual signature.

Clinician Notes: _____

Pediatric Medical History:

Birth History:

Delivered Via: Cesarean Vaginal If C-Section, was it planned? Yes No

Premature: Yes No If yes, gestation: _____ weeks

Length of Pregnancy: _____ Duration of Labor: _____

Birth Weight: _____ Length: _____ List any complications: _____

Did the child require any of the following:

NICU: Yes No

Special Care Nursery: Yes No

Oxygen: Yes No

Incubator: Yes No

Medical History:

Please list other medical history/surgical history/hospitalizations:

Any Allergies? Yes No If yes please list: _____

Please list any medications your child is presently taking: _____

Has your child had hearing screened? Yes No If yes, what were the results? _____

Has your child had vision screened? Yes No If yes, what were the results? _____

Developmental History:

Sat at _____ months/years

Crawled at _____ months/years

Stood at _____ months/years

Ran at _____ months/years

Dressed at _____ months/years

Held head up at _____ months/years

Walked at _____ months/years

Toilet trained at _____ months/years

Fed self at _____ months/years

First single word at _____ months/years

Put words together at _____ months/years

Making sentences at _____ months/years

Was placed on his/her belly as an infant Yes No

Enjoyed belly time as an infant Yes No

Was/is developmentally delayed Yes No

Is good with his/her hands (fine motor skills) Yes No

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

Behavioral/Social History:

Please check all that apply to your child:

- | | |
|---|---|
| <input type="checkbox"/> Makes good eye contact with adults and peers | <input type="checkbox"/> is aggressive |
| <input type="checkbox"/> Is social and engaging | <input type="checkbox"/> Does not like new places/people |
| <input type="checkbox"/> Is well behaved | <input type="checkbox"/> Does not like crowds |
| <input type="checkbox"/> Pays attention | <input type="checkbox"/> Prefers to play alone |
| <input type="checkbox"/> Listens well | <input type="checkbox"/> Has difficulty paying attention |
| <input type="checkbox"/> Plays well with other children | <input type="checkbox"/> Has difficulty paying attention |
| <input type="checkbox"/> Does well with change | <input type="checkbox"/> Is very busy and active |
| <input type="checkbox"/> Understands safety | <input type="checkbox"/> Poor coping skills |
| <input type="checkbox"/> Takes turns with peers | <input type="checkbox"/> Unable to self-calm |
| <input type="checkbox"/> Recalls and tells about day events | <input type="checkbox"/> Extremely sensitive to criticism |
| <input type="checkbox"/> Maintains topic | <input type="checkbox"/> Follows directions |
| | <input type="checkbox"/> Has tantrums |

Please list any behavioral or social concerns:

Please list any previous therapy evaluations completed and recommendations:

Parent/Guardian

Signature: _____ **Date:** _____

By typing your name above you agree that your typed signature can be used as your actual signature.

Occupational Therapy: If seeking occupational therapy for your child, please complete.

What are your primary concerns leading to an occupational therapy evaluation? _____

Describe your child's attention to structured or unstructured play: _____

How does your child spend unstructured time? _____

Self Help: Has your child ever used feeding utensils? Yes No If yes, is assistance needed for success? _____

Physical Therapy: If seeking physical therapy for your child please complete this section.

What are your primary concerns leading to physical therapy evaluation? _____

Has or does your child use braces or orthotics? _____

Has or does your child use any assistive devices? _____

Has your child seen an orthopedic doctors Yes No If yes, when/who/why: _____

Speech Therapy: If seeking speech therapy for your child, please complete this section.

What are your primary concerns leading to a speech-language evaluation? _____

Hearing: Has your child's hearing appeared normal: Yes No If no, please describe: _____

Does your child respond to soft or moderate sounds? _____

Can your child follow instructions which are expected of his/her age Yes No

Speech and Language: Please provide age at which started and example for following categories:

1. Babbling: _____

2. First words: _____

3. Put 2 words together: _____

4. Put 3-4 words together: _____

5. Sentences: _____

Has the speech progress ever been interrupted or reversed? Yes No If yes please describe _____

When was the problem with speech/language first noticed? _____

Did it follow an illness, accident or unusual occurrence? _____

What is your primary language? _____

Do you or your child speak any other languages? _____

What is your and your child's preferred language? _____

Clinician Notes: _____

Parent/Guardian

Signature: _____ **Date:** _____

By typing your name above you agree that your typed signature can be used as your actual signature.

HIPAA Release of Information Authorization Form

I hereby authorize *Michigan Orthopaedic Rehabilitation (MOR)* the ability to send me electronic communication containing my child's personal health information (information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to my child and which identifies my child's name, address, member ID, payment arrangements, and balance information) EXCEPT the following information about my child:

[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY] for the purpose of: helping me to resolve claims or health benefit coverage issues, and the purpose of communication regarding plan of care.

I also allow the MOR staff members involved in the care of my child to email internally to each other and externally to other professionals involved in the care of my child.

I understand that the electronic communication will be sent via an unsecured/unencrypted email network. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid for one year from the date listed below for one year.

I understand that I have a right to revoke this authorization by providing written notice to *Michigan Orthopaedic Rehabilitation*. However, this authorization may not be revoked if *Michigan Orthopaedic Rehabilitation*, its employees, or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my child's eligibility for benefits, enrollment, payment for, or coverage of services.

Parent/Guardian

Signature: _____ **Date:** _____

By typing your name above you agree that your typed signature can be used as your actual signature.

Below please list the names and phone numbers of the parents/guardians you give permission to share your child's health information with.

Name	Relationship to Child	Phone Number

Release of Information Form

Child's Name: _____ Date of Birth: _____

This form allows *Michigan Orthopaedic Rehabilitation* to send and receive evaluations, reports, and other requested information, including sending claims to your insurance provider. If we do not have this form filled out, we will not be able to provide this service on your patient's behalf.

I hereby authorize any physician, clinic, hospital, institution, or school to release Medical and Psychological information regarding my child, (Patient's Name) _____ to *Michigan Orthopaedic Rehabilitation*. I understand that this information is to be used for professional purposes only and that it will be regarded as confidential. I also authorize *Michigan Orthopaedic Rehabilitation* to contact any persons or institutions to obtain any additional information regarding my child when necessary.

I hereby authorize *Michigan Orthopaedic Rehabilitation* to release therapy reports regarding my child, (Patient's Name) _____, to any entity or professional associated with my child's care (physicians, any clinic, hospital, institution, insurance company, school, and other), with the EXCEPTION of _____.

This authorization includes release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions.

Parent/Guardian

Signature: _____ **Date:** _____

By typing your name above you agree that your typed signature can be used as your actual signature.

(OPTIONAL)

I give my permission for *Michigan Orthopaedic Rehabilitation* to photograph and/or videotape my child to use said photos and/or videos for promotional or educational purposes.

Please select one:

Agree

Disagree

Parent/Guardian

Signature: _____ **Date:** _____

By typing your name above you agree that your typed signature can be used as your actual signature.

The release of information consent will expire in one year or after all billing issues related to this treatment will have been resolved. This consent may be revoked at any time through a written request to *Michigan Orthopaedic Rehabilitation*.

Pediatric Cancellation Policy

For pediatric appointments, we block an hour of the therapist's time. We ask to **PLEASE** give us a **24 hour notice** before canceling.

Please review and initial the following:

- A credit card **MUST** be kept on file: _____(initial)

Credit Card#: _____ Exp. Date: _____
CVV: _____ Zip Code: _____

- If appointment is **NOT** canceled within **24 hours**, there will be a **charge of \$100** (Exceptions in case of an emergency) _____(initial)
- **Two** (24 hour) cancels within a month, there will be a **charge of \$100 AND** patient will be taken off schedule (or must speak with treating therapist) _____(initial)

Parent/Guardian

Signature: _____ **Date:** _____

By typing your name above you agree that your typed signature can be used as your actual signature.

Pediatric Appointment Reminders

Please check the best method of communication to contact you:

_____ Voice Calls: Phone Number: _____
_____ Text Message: Phone Number: _____
_____ Email: _____

Please sign that we have permission to leave a voicemail/email you regarding your child's appointment or other treatment matters.

Parent/Guardian

Signature: _____ **Date:** _____

By typing your name above you agree that your typed signature can be used as your actual signature.