Inland Northwest Therapy
Patient information packet

Date of Birth: _____/_____/_____ Age:_____ Gender:_____

Patient's last name: _____ First:_____

Mother's last name: _____ First:_____
M.I._____
Address:_____
City:_____ State:_____
Zip:_____ Home Phone: _____Cell Phone: _____

E-mail Address:
_____

Father's last name: _____ First:_____
M.I._____
Address:_____
City:_____ State:_____
Zip:_____ Home Phone: _____Cell Phone: _____
E-mail Address:
_____

Who referred you to us?
_____

LIVING ARRANGMENTS:
With whom does your child reside? ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Split Custody ☐
Other:_____

Name of patient's primary doctor_____

Office
Address_____

Phone # _____ Fax #_____

PRIMARY INSURANCE INFORMATION:
Insurance Subscriber's Name: _____Subscriber DOB: _____

Name of Insurance Company_____ Provider Phone number: _____

Effective Date: _____

ID # _____

SECONDARY INSURANCE INFORMATION:
Insurance Subscriber's Name: _____DOB :_____

Name of Insurance Company_____

Provider Phone number:_____ Effective Date: _____

Health

Current medications? _____

Allergies:
_____

Does your child have a medical diagnosis? _____

Has your child been diagnosed with or had any of the following: (check all that apply)

☐ Allergies
☐ Attention Disorder
☐ Arthritis
☐ Autism/Pervasive Developmental Disorder
☐ Speech/Language Delay
☐ Auditory Processing Disorder
☐ Congenital Disorder

☐ Meningitis
☐ Heart Disease
☐ Developmental Delay
☐ Learning Disorder

☐ Gastrointestinal Disorder

☐ Diabetes
☐ Enuresis/Encopresis
☐ Anxiety Disorder
☐ Bipolar Disorder
☐ Obsessive-compulsive Disorder

What was your child's birth weight? _____

Were there any complications during the pregnancy/delivery? _____

Was your child born at full term? _____

Did you take any medications during pregnancy? _____

Were alcohol or drugs used during pregnancy? _____

Were there any of the following complications during or after the birth? (Check all that apply)

☐ Assisted delivery
☐ Respiratory difficulties ☐ Cesarean Section
☐ Transfusions
☐ NICU ☐ Feeding Difficulties (sucking, swallowing)
☐ Need for oxygen
☐ Supplemental nutrition ☐ Jaundice
☐ Breech

DEVELOPMENTAL HISTORY

At what age did your child:

_____ Sit up independently
_____ Crawl

_____ Walk

_____ Complete toilet training
_____ Hold a pencil

_____Babble repeated syllables

_____ Speak first word
_____ Put two words together

Specific developmental concerns: _____
_____
_____

_____

SPEECH AND LANGUAGE

What is the primary language spoken in the home?_____
Are there any other languages spoken in the home? _____
How does your child let you know needs? (Check all that apply)

____ Cries
____ Grunts
____ Points
____ Uses gestures
____ Uses a few words says two or three word combinations

What does your child do when he/she needs help with something? _____

When talking to your child, how much does he/she understand? (Check all that apply)

____ Non-responsive ____ Many words and ____ A few words phrases

____ Almost everything ____ Everything I say
.

Can your child usually follow: 1 step directions 2 step directions 3 step directions (circle)

Does anyone in your family talk for your child or interpret his/her speech/gestures?_____

Can people outside your family understand your child's speech?_____

Do you have specific concerns regarding your child's speech and language skills:_____

FEEDING

Do you have any concerns regarding feeding/swallowing?_____

Has your child had a swallow study?:_____

Has your child ever required NG/G feeding tube or intravenous? _____

Did/Does your child nurse/bottle? _____

How do you currently feed your child? _____

If bottle fed, at what age did your child stop using the bottle? _____

Type of formula fed and amount per feeding per day:_____

Did/Does your child suck his/her thumb?_____

Does your child use a pacifier? _____

What types are your child's favorite foods?_____

Non-preferred foods? _____

Does your child have **difficulty** eating certain textures of food? (**Check all that apply**)

___soft foods ___pureed foods___chewy foods ___crunchy foods ____meat

Did/Does your child exhibit any of the following? (**Check all that apply**)

___ Drooling ___ Says words that means food ___ ___ Difficulty swallowing___ Trouble breathing while eating ___ Difficulty latching on to the nipple ___ Food allergies ___ Gagging___ Vomiting___ Difficulty chewing

PLAY SKILLS

Does your child play independently? _____

Does your child share toys with others? _____

Does your child play with other children_____

Does your child play with adults? _____

Preferred toys:_____

AUTHORIZATION AND CONSENT FOR TREATMENT

I consent to and grant permission to the employees of Inland Northwest Therapy to provide care including evaluations, educational services, and therapy activities/procedures during my receipt of services, and to carry out the orders of my child's physician, including consultants, associates and assistants of his/her choice.

_____ Initials

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Inland Northwest Therapy to furnish and release medical information to my private insurance carrier, or other third party payer, as may be required for the determination of benefits payable. I grant permission for Inland Northwest Therapy to communicate all aspects of my child's care with the physician(s) whom I have identified.

_____ Initials

CANCELLATION AND LATE POLICIES

In an effort to serve as many children as possible we maintain a strict no show policy. In order to remain viable and provide services we require at least 48 hours advance notice of a cancellation. We reserve a weekly time slot for your child and slots that go unused are not billable and we are not able to rebook those appointments without at least 48 hours' notice. Please call us to reschedule your appointment so that another child may be booked into your slot.

_____ Initials

I certify that I have read and understand the above policies:

_____ _____

Signature Date

INSURANCE

I understand that all co-pays, deductibles, and co-insurance are due at the time of service. I understand that the benefits stated by my insurance company are not a guarantee of payment or coverage. I understand that specific therapy charges are incurred at each appointment. I understand that I am fully responsible for all charges for services and/or treatment rendered. I will provide a copy of my insurance card each time my insurance information changes and agree that it is my responsibility to keep my insurance information current.

_____ Initials

Acknowledgement of receipt of notice of privacy practices-HIPPA

I certify that I have received a copy of INT notice of privacy practices. The notice of privacy practices describes the types of use and disclosures of my protected health information (PHI) that may occur in my treatment, payment, or in the performance of INT's health care operations. The notice of privacy practices also describes my rights and INT's duties with respect to my protected health information. If you have any questions about this notice please contact our office at 509-624-3115.

Authorized Signature_____

Date_____ Relationship to patient_____