

Medical History

Patient Name: _____

Pregnancy / Delivery

- Pregnancy Proceeded Without Complications
 With Complications
- | | |
|---|---|
| <input type="checkbox"/> Eclampsia | <input type="checkbox"/> Positive for Strep B |
| <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Pre-eclampsia |
| <input type="checkbox"/> Multiple Births | <input type="checkbox"/> Premature Labor |
| <input type="checkbox"/> Polyhydramnios | <input type="checkbox"/> Substance Exposure |
| <input type="checkbox"/> Positive for Cytomegalovirus 'CMV' | <input type="checkbox"/> Toxemia |
| <input type="checkbox"/> Positive for Herpes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Positive for HIV | |

Length of Pregnancy (in weeks) _____

Prenatal care was Received Not Received

- Delivery Proceeded Without Complications
 With Complications
- | | |
|---|---|
| <input type="checkbox"/> Abruptio Placenta | <input type="checkbox"/> Premature Rupture of Membranes |
| <input type="checkbox"/> Breech Presentation | <input type="checkbox"/> Transverse Presentation |
| <input type="checkbox"/> Low Birth Weight | <input type="checkbox"/> Prolapsed Cord |
| <input type="checkbox"/> Negative Vacuum | <input type="checkbox"/> Use of Forceps |
| <input type="checkbox"/> Non-progressive/unproductive Labor | <input type="checkbox"/> Uterine Rupture |
| <input type="checkbox"/> Occiput Posterior Position (Face up) | <input type="checkbox"/> Umbilical Cord Wrapped Around Neck |
| <input type="checkbox"/> Placenta Previa | <input type="checkbox"/> Other _____ |

Delivery was Vaginal C-section Emergency C-section Length of child's hospital stay: _____

Mother's age at time of birth _____ Birth Hospital _____

Needed to be transferred to another hospital Yes No

Transfer Hospital _____

Birth Weight _____ Birth Height _____ Apgar 1 min _____ 5 min _____ 10 min _____

Additional Comments _____

Multiple child pregnancies: # of live births: _____ # of still births: _____

Additional details of birth _____

Complications Following Birth

- Anemia of Prematurity
- Bronchopulmonary Dysplasia 'BPD'
- Cleft Lip
- Cleft Palate
- Club Foot
- Cytomegalovirus
- ECMO
- Failure to Thrive
- Hyperbilirubinemia
- Intrauterine Growth Retardation 'IUGR'
- IVH Bleed Grade I
- IVH Bleed Grade II
- IVH Bleed Grade III
- IVH Bleed Grade IV
- Jaundice treated by light therapy &/or blanket
- Meconium Aspiration
- Necrotizing Enterocolitis 'NEC'
- Neonatal hypoxia
- Oxygen dependency
- PDA
- Positive dependency
- Respiratory Distress Syndrome
- Respiratory Stridor
- Respiratory Syncytial Virus 'RSV'
- Retinopathy of Prematurity 'ROP'
- Thrombocytopenia (Low Platelet count)
- Ventilator Dependency
- VP Shunt
- Other _____

Diagnosed or Suspected Syndromes

Current Medications

Allergies

Current Vitamins, Herbs, Minerals, Homeopathics

Hearing Test

- Never Tested, No Concerns
- Never Tested, Have Concerns
- Normal Test Results
- Abnormal Test Results

Last Test Date _____

Results

Concerns

Vision Test

- Never Tested, No Concerns
- Never Tested, Have Concerns
- Normal Test Results
- Abnormal Test Results

Last Test Date _____

Results

Concerns

Current Physicians

Name	Specialty	Reason	Date of last visit

Diagnostic Tests

Test	When	Details/Results
Auditory Brainstem Response		
Biopsy		
Blood Work / Lab Tests		
Bone Density Scan		
CT Scan		
EEG		
EMG		
Lower GI		
Motility Study / Empty Scan		
MRI		
NCV		
Swallow Study		
Ultrasound		
Upper Endoscopy		
X-Ray		

Surgeries and Procedures

Type	Date	Results/Details

Does the child have:

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Colic | <input type="checkbox"/> Scoliosis Degrees? _____ |
| <input type="checkbox"/> Arteriovenous malformation (AVM) | <input type="checkbox"/> Constipation | <input type="checkbox"/> Seizure Condition |
| <input type="checkbox"/> Anoxic brain injury | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> Asthma/respiratory breathing problems | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Hip subluxation | <input type="checkbox"/> Shunts |
| <input type="checkbox"/> Baclofen Pump | <input type="checkbox"/> Hydrocele | <input type="checkbox"/> Torticollis |
| <input type="checkbox"/> Cerebral Palsy (CP) | <input type="checkbox"/> Laryngomalacia | <input type="checkbox"/> Traumatic brain injury (TBI) |
| <input type="checkbox"/> Cerebral Vascular Accident (CVA) | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Tube Feeding |
| <input type="checkbox"/> Chronic Ear Infections | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tubes in ears |
| | <input type="checkbox"/> Periventricular Leukomalacia | <input type="checkbox"/> Vagal Nerve Stimulator |
| | <input type="checkbox"/> Reflux | <input type="checkbox"/> None |

Other Medical Conditions

Orthopedic Conditions

Additional Comments

Developmental History

Is the child able to:	Began at age (in months):
Bringing both hands to mouth	
Buttoning pants/shirt	
Come to sitting from a lying position	
Creeping or crawling alone	
Fully Toilet trained	
Grabbing a toy	
Holding head up alone	
Pulling self to standing position	
Rolling Over	
Self-bathing	
Self dressing	
Sitting alone without support	
Standing unsupported	
Tying shoes	
Walking with support	
Walking unaided	
Zippering/unzipping jacket	

Is your child Right Handed Left Handed Neither

Concerns about handwriting? Yes No Describe: _____

How does child get around the house? _____

Favorite Toys / Play Activities _____

Description of Child

- | | | | | | |
|---------------------------------------|---|---------------------------------------|-------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Active | <input type="checkbox"/> Cautious | <input type="checkbox"/> Distractible | <input type="checkbox"/> Insecure | <input type="checkbox"/> Playful | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Curious | <input type="checkbox"/> Fearful | <input type="checkbox"/> Motivated | <input type="checkbox"/> Shy | |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Demanding | <input type="checkbox"/> Fearless | <input type="checkbox"/> Passive | <input type="checkbox"/> Stubborn | |
| <input type="checkbox"/> Calm | <input type="checkbox"/> Difficult to Comfort | <input type="checkbox"/> Fussy | <input type="checkbox"/> Persistent | <input type="checkbox"/> Withdrawn | |

Sensory processing & Regulation (please select all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Avoids getting messy | <input type="checkbox"/> Resists certain movements (e.g. bouncing, swinging, upside down) |
| <input type="checkbox"/> Seeks out (craves) touch or movement | <input type="checkbox"/> Has difficulty figuring out how to move body or takes more time with movements |
| <input type="checkbox"/> Stumbles or falls frequently | <input type="checkbox"/> Does not tolerate certain textures (e.g. clothing, surfaces, foods) |
| <input type="checkbox"/> Appears awkward or less coordinated | <input type="checkbox"/> Uses lots of pressure when touching someone or holding object |
| <input type="checkbox"/> Flaps hands | <input type="checkbox"/> Has difficulty transitioning from one activity to another |
| <input type="checkbox"/> Allows brushing of teeth | <input type="checkbox"/> Has difficulty falling asleep |
| <input type="checkbox"/> Bangs on surface, bangs/hits head | <input type="checkbox"/> Has difficulty remaining asleep through the night |
| <input type="checkbox"/> Fatigues quickly | <input type="checkbox"/> Appears Lethargic/sleepy all the time |
| <input type="checkbox"/> Has self-abusive behaviors | <input type="checkbox"/> Has poor sense of body in space, runs into things |
| <input type="checkbox"/> Resists certain tasks or environment | <input type="checkbox"/> Seeks support for posture (e.g. leans on furniture, walls or people, holds head) |
| <input type="checkbox"/> Spins things or self | <input type="checkbox"/> Demonstrates stiff or rigid movement patterns |
| <input type="checkbox"/> Is sensitive to lights, sounds or noise | <input type="checkbox"/> Hyperfocussed (on specific tasks, people, objects, etc.) |
| <input type="checkbox"/> Sleeps a lot | |
| <input type="checkbox"/> Resists touch | |
| <input type="checkbox"/> Walks on toes | Other: please describe _____ |
| <input type="checkbox"/> Lines up toys or objects | |
| <input type="checkbox"/> Seeks out (craves) visually stimulating objects | |
| <input type="checkbox"/> Seeks out (craves) stimulating sounds | |

Social/Emotional Skills

- Is easily distracted
- Calms self easily
- Gets angry/frustrated easily
- Is aggressive towards others
- Prone to emotional outbursts
- Doesn't allow others to join in play
- Has difficulty making friends
- Plays with peers
- Other: please describe _____
- Only plays with adults
- Prefers to play alone
- Has difficulty with separations
- Has poor eye contact

Feeding

Describe Any Feeding Problems

Food Likes

Food Dislikes

Feeding Milestones

When did the child begin?	Age (in months)	Milestone	Age (in months)
Using a Bottle		Using a Straw	
Using a Pacifier		Stop Using a Bottle	
Eating baby food		Stop Using a Pacifier	
Eating junior food		Using Utensils to Eat	
Eating table food		Holding own bottle/cup	
Drinking from a Cup		Self-feeding	
Drinking from a Sippy Cup			

Breast Feeding

- # times currently breast fed per day _____
- Weaned from breast feeding at age: _____
- Was never breast fed

Current Feeding Adaptations

- Thickened Liquids: Consistency: _____
- Adapted Utensils Details: _____
- Adapted seating Details: _____
- Calorie supplements Details: _____
- Tube Feeding Amount: _____ Times per day: _____ Continuous Bolus

Areas of Difficulty

- Chewing
- Drooling
- Transitioning Between Foods
- Jaw shifts/slides/juts
- Communication Needs
- Swallowing
- Understanding Words

Speech Language

Communication Skills

Does the child:	Yes	No
Have speech that is understood by most people?		
Respond correctly to yes/no questions?		
Follow simple instructions?		
Respond when name is called?		
Stutter?		
Recognize objects, people, and places?		

Speech Milestones

When did the child begin?	Age (in months)	Milestone	Age (in months)
Babbling		Putting 2 words together	
Saying first words		Using short sentences	
Naming familiar objects			

First Words _____

Augmentative Communication Device _____

Primary Communication Verbal Non-Verbal None

Methods of communication used:

- | | | | | |
|--|---|---|---|-----------------------------------|
| <input type="checkbox"/> Vocalizations | <input type="checkbox"/> 2 word Phrases | <input type="checkbox"/> Facial Expressions | <input type="checkbox"/> Manual Sign Language | <input type="checkbox"/> Pointing |
| <input type="checkbox"/> Single Words | <input type="checkbox"/> Complete Sentences | <input type="checkbox"/> Body Language | <input type="checkbox"/> Gestures | <input type="checkbox"/> Eye Gaze |

Please describe current speech concerns: _____

Home Environment

Child lives with: (Please select all that apply)

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> Birth mother | <input type="checkbox"/> Step-mother | <input type="checkbox"/> Siblings |
| <input type="checkbox"/> Birth father | <input type="checkbox"/> Step-father | Please list siblings ages: _____ |
| <input type="checkbox"/> Adoptive mother | <input type="checkbox"/> Grandmother | <input type="checkbox"/> other relative |
| <input type="checkbox"/> Adoptive father | <input type="checkbox"/> Grandfather | Please specify: _____ |
| <input type="checkbox"/> Legal guardian | Please specify: _____ | |

Additional Comments: _____

Adoption

Age at adoption: _____

Additional Details: _____

Type of Home

- | | |
|---|---|
| <input type="checkbox"/> Single Level | <input type="checkbox"/> Assisted Living Facility |
| <input type="checkbox"/> 2 Level | <input type="checkbox"/> Skilled Nursing Facility |
| <input type="checkbox"/> Ground Floor Apartment | <input type="checkbox"/> Group Home |
| <input type="checkbox"/> Upper Level Apartment | <input type="checkbox"/> Other _____ |

Accessibility

Stairs to get into home: _____ Handrail? Right Left None

Ramp to get into home? Yes No

Stairs in home: _____ Handrail? Right Left None

- | | |
|--|---|
| <input type="checkbox"/> Bathroom on Main Level | <input type="checkbox"/> Bedroom on Main Level |
| <input type="checkbox"/> Bathroom on Upper Level | <input type="checkbox"/> Bedroom on Upper Level |

Additional Comments: _____

Equipment presently used (Please select all that apply)

Equipment	Approx. Age	Details	Uses at Home	Uses at School/Day Care
Braces				
Walker				
Stander				
Manual Wheelchair				
Power Wheelchair				
Hoyer Lift				
Weighted Vest				
Hand Splint(s)				
Track System				
Other:				

Describe any home program that is currently performed (e.g. stretching, strengthening, brushing, etc)

Describe any community groups or sports activities the child is involved in

Grade in School _____ Name of School _____

Does your child have an IFSP? Yes No

Does your child have an IEP from school? Yes No

Has your child had a psychological or neuropsychological evaluation completed? Yes No

Therapy Services	Type	Status	How often?	Where?
Assistive Technology				
Audiology				
Behavior Therapy				
Developmental History				
EI Services				
Intensive Suit Therapy				
Vision Therapy				
Nutrition				
Occupational Therapy				
Physical Therapy				
Social Therapy				
Speech / Language Therapy				
Developmental Follow-up Clinic				
Other:				

Additional Comments: _____

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 _____