wild & free

PEDIATRIC THERAPY

Patient Intake Form

Primary Physician or Referring Physician:________________________________

Reason for Referral:________________________________

PATIENT INFORMATION

Legal Name:________________________________

Patient Date of Birth:______________ Age:____________ Gender:____________

Current Diagnosis:________________________________

Parent/Guardian #1:________________________________

Relationship to Child:________________Custody Status:________________

Address:____________________City:____________State:______Zip:_______

Preferred Phone Number:____________Home/Cell Secondary:____________Home/Cell

Email:________________________________

Parent/Guardian #2:________________________________

Relationship to Child:________________Custody Status:________________

Address:____________________City:____________State:______Zip:_______

Preferred Phone Number:____________Home/Cell Secondary:____________Home/Cell

Email:________________________________

Primary Language:________________Language Spoken at Home:________________

Siblings (name and ages):________________________________

What are your primary areas of concern/What are you hoping for the therapist to address?

___

___

___

What are your goals for therapy?

___

___

___

Does your child ever complain of pain? If so, in what area? Please describe:

___

___

___

Please list any medical precautions/allergies/medications:

___

___

___

Is your child receiving any other services? (i.e. Speech Therapy, Physical Therapy, Occupational Therapy, Special Education, Early Intervention)

___

___

___

What (if any) special equipment does your child use? (i.e. wheelchair, crutches, walker, braces, glasses, hearing aids, communication device)

___

___

___

Please list any significant prenatal or birth history:

___

___

___

- ☐ Premature (Gestation: ______weeks)
- ☐ Full Term
- ☐ Low Birth Weight (________lbs)
- ☐ Breech Birth
- ☐ C-section Birth (Planned)
- ☐ Emergency C-section
- ☐ Vaginal Birth
- ☐ Forceps Delivery
- ☐ Vacuum Delivery
- ☐ Preeclampsia
- ☐ Gestational Diabetes
- ☐ Breast Fed _________________
- ☐ Poor suction/latch
- ☐ Bottle Fed _________________
- ☐ Oxygen at Birth
- ☐ NICU Stay (Duration in NICU:____________)
- ☐ Other:_____________________________________

MEDICAL HISTORY

Please list any significant illness, hospitalizations, etc.:

___

___

___

- [ ] Chronic ear infections
- [ ] Tubes
- [ ] Tonsils/Adenoid Surgery
- [ ] Reflux
- [ ] Surgeries (list above)
- [ ] Poor weight gain
- [ ] Gastrointestinal Issues
- [ ] Poor sleep
- [ ] Asthma
- [ ] Abnormal muscle tone
- [ ] Torticollis
- [ ] Plagiocephaly
- [ ] Frequent Fevers
- [ ] Seizures
- [ ] Compromised Immune System
- [ ] Abnormal Lab Results
- [ ] Cardiac Issues
- [ ] Other:___

DEVELOPMENTAL HISTORY

Fill in the blanks to describe your child to the best of your ability:

Sat at ___months/years
Crawled at ___months/years
Stood at ___months/years
Walked at ___months/years
Ran at ___months/years
Fed self at ___months/years

First single words at ___months/years
Put words together at ___months/years
Making sentences at ___months/years
Dressed at ___months/years
Toilet trained at ___months/years

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

___

___

___

Please list any concerns with feeding/eating or allergies.

___

___

Please list any concerns with speech or hearing.

___

___

AUTHORIZATION OF TREATMENT

My signature below is confirmation that I have informed Wild and Free Pediatric Therapy of all necessary Information and have answered all questions truthfully and to the best of my ability. I authorize the therapists of Wild and Free Pediatric Therapy to administer such treatment as is prescribed and considered therapeutically necessary on the basis of findings during the course of treatment.

______________________________________ ____________________

Parent Signature Date

Sick Child Policy

When your child is sick, his/her performance in therapy is not optimal, and in turn, is less beneficial. Therefore, we have established the following illness exclusion policy which adheres to the Centers for Disease Control and Prevention (CDC) Infection Control guidelines.

Your child must be symptom-free for 24 hours, without the use of medications including Tylenol. Therapy will not occur if your child has exhibited any one of the following symptoms within the last 24 hours:

- Fever of 100º or higher
- Diarrhea (runny, watery or bloody stools)
- Vomiting (twice or more in 24 hours)
- Body rash with fever
- Sore throat with fever and swollen glands
- Severe coughing
- Eye discharge (thick mucus draining from eye, or pink eye)
- Yellowish skin or eyes
- Upper respiratory illness such as bronchitis or influenza
- Chicken pox or Hand, Foot, and Mouth (until all blisters have dried and formed scabs)
- Bacterial infection (Impetigo, Strep Throat, etc.)
- Viral infection
- Any parasitic infestation (Lice, Scabies, etc.)
- Extreme irritability, exhaustion, or continuous crying

In the event that your child is exhibiting any of the above symptoms we ask that you contact your therapist as soon as possible to reschedule your appointment.
If you are unsure regarding your child's status, please contact your therapist and they will use their discretion in deciding whether therapy should occur as scheduled. In the event you arrive for an appointment and find your child is exhibiting any of the above listed symptoms, we reserve the right to cancel the session and attempt to reschedule for a later date.

Because we work so closely to your child, our concern is not only your child's health, but also maintaining the health of our staff and other patients. Thank you for adhering to this sick policy.

Attendance and Cancellation Policy
At Wild and Free Pediatric Therapy our goal is to provide quality therapy within a timely manner. In order to do so, we have established a cancellation/no show policy. This policy will help ensure that appointment times are available throughout the day.

- Please contact the clinic or your therapist before 9:00 am the morning of your appointment if you need to cancel/reschedule due to illness or emergency.
- Please provide at least 24 hours notice of a cancellation for a planned absence.

We understand there will be times when your child is sick or other unavoidable events will prevent you from keeping your regularly scheduled therapy appointment. If this occurs, we ask that you contact your therapist as soon as possible so they have the opportunity to reschedule the missed appointment and fill your child's time slot with another appointment. Our therapists will do whatever they can to be available to your child and accommodate your family's schedule when making appointments. It is expected, in turn, that you will schedule appointments in good faith and facilitate adequate time in your schedule to keep your child's therapy a priority.

If the clinic or therapist is not informed before 9:00 for illness (unless your child develops symptoms of fever, vomiting, or diarrhea and has to be picked up from school) or at least 24 hours before a planned absence then the visit will be considered a "NO-SHOW". A NO-SHOW status is defined as a patient who has failed to be present at the time of their scheduled appointment. Wild and Free Pediatric Therapy will follow a 3 strike rule for NO-SHOW within a 6 month period. After 3 NO-SHOW appointments you may be taken off the therapy schedule. In addition, patients with less than 75% attendance to scheduled appointments will be removed from standing appointment spots.

Pick up Policy If you need to leave during your child's scheduled therapy time, you must arrive 10 minutes before the end of the session. Please confirm with the therapists your expected return time at the beginning of the session. After 2 late returns, you will not be able to leave the premises during your child's therapy session.

The intent of these policy's is to prevent delays in care and utilize therapist time more efficiently by reducing unused appointment slots. Wild and Free Pediatric Therapy reserves the right to charge $25.00 for any appointments that are considered a NO-SHOW or late cancellation. An invoice for the missed appointment will be sent out and payment is due upon receipt if card is not on file. We appreciate your attention to our attendance and cancellation policy, and request that you comply with all cancellations in a timely manner. Thank you for your cooperation! By signing below, you agree to the Sick Child Policy and Attendance and Cancellation Policy of Wild and Free Pediatric Therapy.

______________________________________ ____________________
Parent Signature Date

INSURANCE INFORMATION
(Please present your insurance card to the front desk for scanning.)

Primary Insurance____

Subscribers Name ____________________________ DOB:_______________________________

ID Number_______________________________Group Number___________________________

Secondary Insurance____

Subscribers Name ____________________________ DOB:_______________________________

ID Number_______________________________Group Number___________________________

I hereby authorize my insurance benefits to be paid directly to the provider of these services. I am financially responsible for any balance due, including services that are not covered by my insurance plan. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. A photocopy of this document is considered as valid as the original. If appointments are cancelled with less than 24 hour notice there is a $25 cancellation fee that will be the patients responsibility.

____ ________________________

Parent Signature Date

How did you find out about us? ☐ Your Physician ☐ Website ☐ Advertisement

☐ Social Media ☐ Friend ☐ Other__________________________