

# NEW PATIENT PACKET



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**Client History & Information**

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Gender \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Mother's Name: \_\_\_\_\_ Fathers Name: \_\_\_\_\_

Need street address/No mail box numbers

Mailing Address: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Insurance Subscriber's Name: \_\_\_\_\_ DOB of Subscriber \_\_\_\_\_

SS# of Subscriber \_\_\_\_\_ (Necessary for Insurance Claims)

Home Phone # \_\_\_\_\_ Home Phone # \_\_\_\_\_

Alternate phone# \_\_\_\_\_ Alternate phone # \_\_\_\_\_

Email \_\_\_\_\_ Email: \_\_\_\_\_

**Responsible Party Information:**

Name: \_\_\_\_\_ Occupation/Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone number for providers \_\_\_\_\_

**(Baby Steps Therapy does not accept HMO insurance. You must have a PPO type of insurance).  
If you have TriWest insurance, we will need a copy of your military ID.**

With whom does the child reside? \_\_\_\_\_

Please include all siblings and their age's \_\_\_\_\_

School your child attends \_\_\_\_\_

Grade in school \_\_\_\_\_

What are your main concerns regarding your child?

Has your child received any type of therapy before? (Physical, Occupational, Speech, Psychological) If so, where and for how long?

Is there any family history of learning disability, attention, behavior concerns?

What are your child's strengths/areas of interest?

Is there any history of mental health disorders (including but not limited to anxiety or depression)? If so please indicate what.

**MEDICAL HISTORY**

What is your child's current height and weight? \_\_\_\_\_

**Patient's primary care physician:** First name \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Does your child see any other physicians / specialists that you would like us to know about?

Does your child have a medical diagnosis? If yes, please state.

List any previous medical/surgical procedure and/or hospitalizations (include date and explain).

Has your child ever been exposed to a contagious illness or required contact isolation (CMV, MRSA, TB)? If so please explain.

List any medications your child currently takes and for what condition? \_\_\_\_\_

Has your child ever been on a long-term program of medication?

Does your child have any allergies?    Yes    No

Name of food or drug  
allergy \_\_\_\_\_

Has your child had any operations?    Yes    No

Date:	Type:	Purpose:
_____	_____	_____
_____	_____	_____

**GENERAL HEALTH:**

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

- |   |  |
|---|--|
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Attention Disorder                      |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Autism/Pervasive Developmental Disorder |
| <input type="checkbox"/> Chronic Ear Infections   | <input type="checkbox"/> Asperger's Syndrome                     |
| <input type="checkbox"/> Nerve Injury             | <input type="checkbox"/> High Fevers                             |
| <input type="checkbox"/> Speech/Language Delay    | <input type="checkbox"/> Auditory Processing Disorder            |
| <input type="checkbox"/> Congenital Disorder      | <input type="checkbox"/> Meningitis                              |
| <input type="checkbox"/> Heart Disease            | <input type="checkbox"/> Developmental Delay                     |
| <input type="checkbox"/> Orthopedic Injuries      | <input type="checkbox"/> Brain Injury                            |
| <input type="checkbox"/> Cerebral Palsy           | <input type="checkbox"/> Sensory Processing Disorder             |
| <input type="checkbox"/> Respiratory Difficulties | <input type="checkbox"/> Gastrointestinal Disorder               |
| <input type="checkbox"/> Seizures                 | <input type="checkbox"/> Other Behavioral/Psychological Disorder |
| <input type="checkbox"/> Learning Disorder        | <input type="checkbox"/> Diabetes                                |
| <input type="checkbox"/> Enuresis/Encopresis      | <input type="checkbox"/> Anxiety Disorder                        |
| <input type="checkbox"/> Bipolar Disorder         | <input type="checkbox"/> Obsessive-compulsive Disorder           |

**Comments:** \_\_\_\_\_

Describe any concerns about sleep habits (e.g. restlessness, staying up late, difficult to arouse in the morning)  
Indicate number of hours of sleep per night.

**PREGNANCY AND BIRTH HISTORY**

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? Describe

Was alcohol or drugs used during pregnancy?

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

- |   |   |
|---|---|
| <input type="checkbox"/> Assisted delivery                          | <input type="checkbox"/> Respiratory difficulties |
| <input type="checkbox"/> Cesarean                                   | <input type="checkbox"/> Transfusions             |
| <input type="checkbox"/> NICU                                       | <input type="checkbox"/> Congenital Defects       |
| <input type="checkbox"/> Feeding Difficulties (sucking, swallowing) | <input type="checkbox"/> Tube feeding             |
| <input type="checkbox"/> Hypotonia                                  | <input type="checkbox"/> Need for oxygen          |
| <input type="checkbox"/> Supplemental nutrition                     | <input type="checkbox"/> Jaundice                 |
| <input type="checkbox"/> Breech                                     |   |

**SELF HELP SKILLS: Mark "I" for Independent, "N" for Needs Help**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Bathing        | <input type="checkbox"/> Eating       |
| <input type="checkbox"/> Brushing Teeth | <input type="checkbox"/> Finger Foods |
| <input type="checkbox"/> Brushing Hair  | <input type="checkbox"/> Utensils     |
| <input type="checkbox"/> Dressing       | <input type="checkbox"/> Fork         |
| <input type="checkbox"/> Pants          | <input type="checkbox"/> Spoon        |
| <input type="checkbox"/> Shoes          | <input type="checkbox"/> Drinking     |
| <input type="checkbox"/> Socks          | <input type="checkbox"/> Open cup     |
| <input type="checkbox"/> Shirt          | <input type="checkbox"/> Straw        |
| <input type="checkbox"/> Tie shoes      | <input type="checkbox"/> Sippy cup    |
| <input type="checkbox"/> Buttoning      | <input type="checkbox"/> Toileting    |
| <input type="checkbox"/> Zipping        | <input type="checkbox"/> Snapping     |

**DEVELOPMENTAL HISTORY**

*At what age did your child: (If unsure of exact ages, please note whether each milestone was early, on-time or delayed)*

- |  |  |
|--|--|
| <input type="checkbox"/> Lift head when lying on stomach | <input type="checkbox"/> Pull to stand               |
| <input type="checkbox"/> Roll over stomach to back       | <input type="checkbox"/> Walk independently          |
| <input type="checkbox"/> Roll over back to stomach       | <input type="checkbox"/> Hold a pencil/make markings |
| <input type="checkbox"/> Sit up when placed              | <input type="checkbox"/> Coo prolonged verbal sounds |
| <input type="checkbox"/> Sit up independently            | <input type="checkbox"/> Babble repeated syllables   |
| <input type="checkbox"/> Crawl on belly                  | <input type="checkbox"/> Speak first word            |
| <input type="checkbox"/> Creep on hands or knees         | <input type="checkbox"/> Put two words together      |
| <input type="checkbox"/> Complete toilet training        |  |

**Additional Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SENSORY**

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

- Avoid playing with messy things
- Dislike bathing
- Object to being touched
- Avoid using hands
- Appear to be irritated by certain clothing
- Overreact to having his/her face washed
- Have trouble being close to others
- Tolerate teeth brushing
- Discriminate odors
- Chew on non-food substances

- React negatively to smell
- Explore by smelling
- Act as though all foods taste the same

**BODY AWARENESS (*proprioception*)**

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

- Hold his/her hands in a strange position
- Unintentionally push/hit others when intending to express affection
- Have difficult assuming or sustaining a grasp on a pencil or crayon
- Drop things or bump into things frequently
- Unintentionally break things/toys
- Have difficulty drawing or with handwriting

**MOVEMENT & BALANCE (*vestibular*)**

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

- Rock himself/herself
- Jump excessively
- Get car sick
- Avoid movement activities
- Appear to have good balance
- Like being tossed in the air
- Like merry go rounds or spinning
- Show fear of playground equipment
- Prefer seated activities and appear reluctant in playground participation
- Prefer to play in the house rather than on the playground with other children
- Squat to stand or jump up from the floor
- Hop on one foot
- Catch a ball
- Throw a ball
- Kick a ball
- Walk on his/her toes
- Have difficulty cutting
- Hold a pencil in a 3-point grasp
- Have trouble walking up/down stairs
- Have difficulty hopping, jumping, or running

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **SPEECH AND LANGUAGE**

What is the primary language spoken in the home?

Are there any other languages spoken in the home? (If so, which one(s))

*How does your child usually let you know what he/she wants? (Check all that apply)*

- Cries
- Grunts
- Points
- Uses gestures
- Makes different sounds
- Uses a few words says two or three word combinations
- Uses long sentences

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

What happens if you can't figure out what your child is asking for? What does your child do?

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

- Non-responsive
- A few words
- Many words and phrases
- Simple directions
- Simple questions
- Almost everything I say
- Everything I say

At what age did your child:

- Use single words
- Two word sentences
- Complex sentences

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?

Did your child's speech and language develop and then seem to stop?

Does your child sometimes speak phrases heard in the past, yet repeat them out of context?

## HEARING

Do you suspect a hearing problem?

Has your child had surgery to place tubes in the ears? If so, when? How old? Still in?

Does your child talk in a loud voice or turn up the volume on the TV/radio?

Has your child had a hearing test? If so, when and what were the results?

## FEEDING

Do you have any concerns regarding feeding/swallowing?

Has your child ever required supplemental nutrition via NG/G feeding tube or intravenous?

Did/Does your child nurse? How long? Why discontinued?

Did/Does your child take a bottle? How long? Why discontinued?

Does your child have swallowing problems?

Has your child ever had a swallow study? If so, when, where, and what were the results?

How do you currently feed your child?

totally by mouth

totally by NG/G tube

both: mouth and NG/G feeding tube

bottle only

breast only

table food

baby food

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

What types of foods are the easiest for your child to eat?

What types are your child's favorite foods?

What foods/type of foods does your child refuse? Do fluids leak through your child's nose when drinking?

Did/Does your child use a sippy cup? At what age did they stop?

## NON-ORAL FEEDING (only if applicable)

Formula name:

Total Volume of Formula per Day:

Formula Concentration (e.g., 20 cal/oz, 24 cal/oz):

Did/Does your child suck his/her thumb? When did he/she stop?

Did/Does your child use a pacifier? When did he/she stop?

How long does it take your child to eat/feed at each meal?

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

- soft foods
- pureed foods
- chewy foods
- crunchy foods

Where does your child eat? (Check all that apply)

- High chair
- Kitchen table
- Booster seat
- Lying down
- Lap
- Couch/floor
- Other: \_\_\_\_\_

Does your child indicate to you that (s)he is hungry? If yes, check all that apply.

- Wake up
- Cries and/or screams
- Points
- Says words that means food
- My child does not act hungry

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

- Drooling
- Gagging
- Vomiting
- Retching
- Difficulty chewing
- Difficulty swallowing
- Trouble breathing while eating
- Difficulty latching on to the nipple
- Food allergies

Comments \_\_\_\_\_

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**EDUCATION**

Please list the schools, including, preschools and early childhood programs, your child has attended.

School Age	Grade	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever repeated a grade? Which grade?

How often has your child moved or changed schools?

Do you have any concerns about your child's schools performance?

**SOCIAL-EMOTIONAL**

	YES	NO
Does your child attend to an activity for 10-15 minutes?	_____	_____
Does your child play independently?	_____	_____
Does your child demonstrate frequent mood changes?	_____	_____
Does your child separate easily from you?	_____	_____
Does your child have difficulty changing tasks/activities?	_____	_____
Is your child easy to discipline?	_____	_____
Is your child easily frustrated?	_____	_____
Does your child share toys with others?	_____	_____
Does your child play with other children?	_____	_____
Does your child play with adults?	_____	_____
Does your child play with pets?	_____	_____

What kinds of toys does your child play with most often?

Does your family have any religious or cultural beliefs that would affect therapy for your child?

Please describe any major life stresses your child has experienced (e.g. death of a loved one, severe illness/disability in the family, divorce, etc...) What age was your child when the stressor occurred?

Has your child seen or experienced any kind of verbal, physical, sexual abuse or violence? If yes, please explain.

Is there any additional information that would help us to better understand your child and/or your concerns?

**Minor Release Form**

I give Baby Steps Therapy Inc., permission to publish in print or electronic format, the likeness, image or video of my child taken in the school setting. I release all claims for compensation related to use of the materials. I also acknowledge that Baby Steps Therapy Inc. may choose not to use the photo(s) at this time, but may do so at its own discretion at a later date.

I also understand that once the image is posted on Baby Steps Therapy Inc. website, the image can be downloaded by any computer user. Further, I understand my child's picture and this photo release form will be maintained by Baby Steps Therapy Inc. I understand I may change or withdraw this release/consent at any time by contacting Baby Steps Therapy Inc. in writing to the above address.

\_\_\_\_\_  
Minor's Name (Please print)

\_\_\_\_\_  
Your Name (Parent or Guardian, Please print)

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Date

**General Guidelines:** It is recommended that a release be obtained when photographing or videotaping a minor (under 18). A signature of a parent or guardian is required; signatures of minors are not sufficient. When images are published, Baby Steps Therapy Inc will take cautionary steps to provide minimum identifying information and will not use specific street or mailing addresses, e-mail addresses, or phone numbers. If you have questions, please contact Baby Steps Therapy Inc at 916-415-0119.

**Conditions of Admission**

**Patient's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Authorization and Consent for Treatment**

I consent to and grant permission to the employees of Baby Steps Therapy, Inc. to render to my child routine clinical 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. I also acknowledge that Baby Steps Therapy, Inc. has not made any guarantee or warranty as to the results of any services or treatments given.

\_\_\_\_\_  
Initials

**Authorization for Release of Information**

I hereby authorize Baby Steps Therapy, Inc. 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. Respecting my

privacy and anonymity, I understand that my child's records may be reviewed for statistical purposes. I grant permission for Baby Steps Therapy, Inc. to communicate all aspects of my child's care with the physician(s) whom I have identified.

\_\_\_\_\_  
Initials

**Valuables**

I understand that Baby Steps Therapy, Inc. does not assume responsibility for personal property brought to or left at the facility. I have been advised to leave personal property at home, unless specifically requested by a therapist to assist in my child's treatment.

\_\_\_\_\_  
Initials

**Photography/Video Release**

I **do** / **do not** (circle one) give consent for Baby Steps Therapy, Inc. to take photographs and /or video for clinical, educational, and/or celebratory purposes.

\_\_\_\_\_  
Initials

**Overdue Accounts**

**Account balances must be paid within (30) days of the date billed.** A due date will appear at the bottom of the invoice; if other arrangements have not been made then the credit card on file will be charged the balance due. If the credit card on file is refused you will be sent a follow-up reminder notice of payment due. After (90) days ,the account will be turned over to collections.

\_\_\_\_\_  
Initials

**Cancellation & Late Policy**

I understand that a fee of \$50.00 will be due upon the next scheduled visit if notice of a cancellation is received less than 48 hours before the scheduled appointment time, or if I fail to show up for any scheduled appointment. I further understand that three consecutive cancellations and/or "no shows" (a missed appointment without communication to our office), or habitual cancellations will result my child being discharged from therapy.

I understand that if I leave the clinic I am expected to return at 15 minutes before the end of the session. I also understand that the treatment session will end at the scheduled time, regardless of my late arrival.

\_\_\_\_\_  
Initials

**Certification**

I certify that any and all information given by me to Baby Steps Therapy, Inc. is correct, to the best of my knowledge. I agree that a copy of this form shall be valid as the original and will not expire. I have read this form (or it has been read to me) and I certify that I understand and agree to all of its conditions.

\_\_\_\_\_ Signature

\_\_\_\_\_ Date

**Insurance Notice**

- All parents are expected to know and understand their coverage and benefits for therapy services. You can verify your benefits by calling the phone number on your insurance card and asking a representative from your insurance company. It is very important that you ask specifically about any "exclusions" or "limitations" to therapy benefits.
- I have called my insurance company to confirm benefits for OT \_\_\_\_\_ or Speech therapy \_\_\_\_\_. My annual deductible is \$ \_\_\_\_\_. My out of pocket per visit is \$ \_\_\_\_\_ or \_\_\_\_\_%. I understand I am liable for the difference between the covered amount and the total fee charged if my insurance company is out of network. \_\_\_\_\_ (initials).
- Please remember that your insurance policy is between you and your insurance company. A quote of benefits from your insurance company is not a guarantee of payment.
- In the event your insurance chooses not to pay for services, you are responsible for all charges.
- It is illegal for our company to waive the co-pay portion of your responsibility. Co-payments are due at the start of each session. We accept check or credit card.
- If you are utilizing insurance, you must obtain a prescription for your evaluation from your child's primary doctor. It must state the reason you are being seen, and it must contain a diagnosis code. We need this prescription PRIOR to your appointment.

\_\_\_\_\_  
Patient / Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

**Insurance**

I understand that co-pays, deductibles, and co-insurance are due at the time of service. If I am unable to provide Baby Steps Therapy, Inc. with my current insurance information prior to my child's appointment, I will pay in full for that day's visit. I agree that I am responsible for knowing and understanding my insurance benefits as they relate to therapy services. I understand that the benefits stated by my insurance company are not a guarantee of payment or coverage, and all insurance payments are subject to medical necessity and eligibility at the time services are rendered. I understand that an office visit and specific therapy charges are incurred at each appointment. I understand that I am fully responsible for all charges for services and/or treatment rendered, and I further agree that all amounts are due upon request and are payable to Baby Steps Therapy, Inc. I will provide Baby Steps Therapy, Inc. with a copy of my insurance card each time I receive a new card and/or my insurance information changes. I understand that if my insurance company delays payment or is waiting on additional information from me before they render payment, and the balance is past 45 days, the balance is my responsibility and is due immediately.

\_\_\_\_\_  
(Please sign)

**Initials**

### Acknowledgment of Notice of Privacy Practices

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Baby Steps Therapy, Inc. **Notice of Privacy Practices** describes in detail how your child's health information may be used and disclosed and explains how you can access your child's information. A copy of the Notice of Privacy Practices has been provided to me.

\_\_\_\_\_  
Patient / Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

### SICK POLICY

**Baby Steps Therapy has a strictly enforced sick policy to protect the health of our therapists and other children in the clinic. If your child has or has had a fever, runny nose with colored discharge or a persistent cough in the last 24 hours, we will not see your child. Please call us to reschedule your appointment.**

\_\_\_\_\_  
Initials