



410 New Bridge Street Suite 10-A
 Jacksonville, NC 28540
 Phone: 910-347-2212
 Fax: 910-347-6003 **OR** 910-338-5013
www.jzmannpediatrictherapy.com
 Email: therapist@jzmannpediatrictherapy.com

On the questionnaire that follows, you are going to be asked or a lot of information about your child. This is a comprehensive questionnaire that addresses concerns related to physical, occupational, and speech therapy. Many questions, and/or entire sections, may not be relevant to your concerns about your child or the reason your child’s physician referred him/her to J.Z. Mann Pediatric Therapy – in that case, either cross out the question/section or write “n/a” as an answer. We want the evaluation of your child to be thorough and complete and your assistance in filling out this questionnaire as thoroughly as possibly is important. **Thank you and WELCOME to J.Z. Mann Pediatric Therapy!**

PARENT QUESTIONNAIRE – INJURY INFORMATION

Child’s Name: _____ / _____ / _____
Last First Middle

Date of Birth: ____/____/____; Sex: Male Female; Mother’s age at birth of child: ____ Father’s age: ____

FAMILY INFORMATION: Child lives with: Mother Father Other: _____

Is DSS involved with the care of this child: NO YES (DSS Caseworker: Name _____ Phone#: _____)

Primary Guardian	Secondary Guardian
Relationship: (<input type="checkbox"/> mother, <input type="checkbox"/> father, <input type="checkbox"/> step-mother, <input type="checkbox"/> step-father, <input type="checkbox"/> grandmother, <input type="checkbox"/> grandfather, <input type="checkbox"/> _____)	Relationship: (<input type="checkbox"/> mother, <input type="checkbox"/> father, <input type="checkbox"/> step-mother, <input type="checkbox"/> step-father, <input type="checkbox"/> grandmother, <input type="checkbox"/> grandfather, <input type="checkbox"/> _____)
Name:	Name:
Full Address:	Full Address:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Occupation:	Occupation:
Employer:	Employer:
Please specify languages, other than English, spoken in the home:	

Parents are: married separated divorced widowed unmarried

If you have other children, please list:

Name	Age	Male or Female?
		M or F
		M or F
		M or F

PHYSICIAN INFORMATION: Please list any doctors the child has seen in the past 12 months on the attached **Confidential Release of Information** so we may obtain pertinent records.

SIGNIFICANT MEDICAL INFORMATION: Check if more than 6, then please provide separate list.

Allergies / Seizures / Major Illness / Injury / Surgery / Swallow Study	Date of event	Physician	Location (Clinic/ Hospital)

OTHER SERVICES CHILD RECEIVES OR HAS RECEIVED IN THE PAST 12 MONTHS:

Type of Service:	Name of Agency/Provider	Frequency:
Physical Therapy		
Occupational Therapy		
Speech Therapy		
ABA Therapy		
Infant Toddler Program (ITP)	<input type="checkbox"/> CDSA or <input type="checkbox"/> EDIS Service Coordinator:	

School Attending: _____ Grade: _____ Does the child have a current IEP? YES NO

Has child had any psychological testing / behavioral testing? NO YES _____
list when & who did testing

Community/Recreational activities child is involved in: _____

MEDICATIONS THAT CHILD CURRENTLY TAKES: Check if more than 5, then please provide separate list.

Name of medication	For (e.g. asthma, etc...)	Dosage/Frequency

INJURY HISTORY:

How did the injury originally occur? _____

When did the injury originally occur? _____

What treatment was done during the first 48 hours of the injury? _____

What treatment has been done from 48 hours after the injury to now? _____

Please describe the swelling initially (first 24 hours) & subsequently after the injury: _____

Rate the level of pain at the time of the injury, with 0 being no pain & 10 being severe pain:

0 1 2 3 4 5 6 7 8 9 10

Rate the level of pain at the current time, with 0 being no pain & 10 being severe pain:

0 1 2 3 4 5 6 7 8 9 10

Please describe the pain (burning, stabbing, radiating, etc.) & when it occurs (all the time, when doing _____
when moving _____, etc.): _____

What activities is the child currently doing that aggravate the injury or the injury inhibits his/her ability to do: _____

INSURANCE INFORMATION: Please provide our clinic with **current** copies of **ALL** of your child's insurance cards.

Name of child's **primary** insurance company: _____ Policy #: _____

Policy holder's name: _____ Sponsor's DOB: ____/____/____ & SSN: ____-____-____

Name of child's **secondary** insurance company: _____ Policy #: _____

Policy holder's name: _____ Sponsor's DOB: ____/____/____ & SSN: ____-____-____

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY:

____ (please initial) I am responsible for payment of any deductible and co-payment/co-insurance amounts, as well as any non-covered amounts as determined by my insurance company. Any payments due are expected at the time of the appointment.

____ (please initial) I understand that J.Z. Mann will send me a bill for any remaining balance on my account and I agree to pay said bill on receipt. I prefer for this bill to be: [choose one]

____ mailed to me at my mailing address on file with J.Z. Mann;

____ emailed to: _____@_____.com I further understand that anyone who has access to this email account will be able to see my outstanding balance.

HEALTH INSURANCE CLAIM:

I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to J.Z. Mann Pediatric Therapy for services provided.

Patient's or authorized person's signature

Date

COMMUNICATION PREFERENCE:

By providing us with your mobile number you authorize J.Z. Mann Pediatric Therapy to communicate with you via text messaging for appointment offers and appointment reminders.

Current Mobile Number(s) for texting
(Leave this blank if you do NOT wish to be texted)

If you wish for us NOT to text you please choose one of the following options:

____ Please CALL me at the following number(s): _____

____ Please EMAIL me at the following address: _____
(Please print clearly)

I wish my child to be evaluated and/or treated by J.Z. Mann Pediatric Therapy, Inc.

Signature

Relationship to Child

Date