J.Z. MANN PEDIATRIC THERAPY

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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 / PAIN INFORMATION

Patient's Name: _____/_____/_____
Last **First** **Middle**

Date of Birth: ____/____/_____; Sex: □ Male □ Female; Mother's age at birth of patient: ____ Father's age: _____

FAMILY INFORMATION: Patient lives with: □ Mother □ Father □ Other: _____

Is DSS involved with the care of this patient: □ NO □ YES (DSS Caseworker: Name_____ Phone#: _____)

Primary Guardian	**Secondary Guardian**
Relationship: (□ mother, □ father, □ step-mother, □ step-father, □ grandmother, □ grandfather, □ _____)	Relationship: (□ mother, □ father, □ step-mother, □ step-father, □ grandmother, □ grandfather, □ _____)
Name:	Name:
Full Address:	Full Address:
Home Phone: Cell Phone:	Home Phone: Cell Phone:
Occupation: Employer:	Occupation: 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

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PHYSICIAN INFORMATION: Please list any doctors the patient 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)	□ CDSA or □ EDIS Service Coordinator:	

School Attending: _____ **Grade**: _____ **Does the patient have a current IEP**? □ YES □ NO

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

Community/Recreational/Program activities patient is involved in: _____

School athletics/dance/martial arts: _____

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

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

INJURY / PAIN HISTORY:

Location of injury/pain? _____

Secondary areas involved? _____

How did the injury or pain originally occur? _____

_____

When did the injury or pain originally occur? _____

_____

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

_____

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

_____

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

_____

Rate the level of pain at the time of the injury or incident, 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 patient currently doing that aggravate the injury or the injury or increase the pain? What activities are limited by pain/injury: _____

_____

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

Revised 12/13/18