

CHILD'S BIRTH/MEDICAL HISTORY:

Length of pregnancy? _____ Birth weight: _____ lbs _____ oz Hospital of birth: _____
Length of labor: _____ Length of Delivery: _____ Was labor induced: YES NO
Birth was: vaginal; caesarean; breech; twins or more Apgar scores, if known: _____ & _____
Length of time after birth that child was discharged from hospital: _____

Problems during pregnancy/labor/delivery: YES NO *If yes, explain:* _____

Vacuum Extraction? YES NO Forceps Used? YES NO Was child on Ventilator? YES NO

Did child spend time in NICU after birth? YES NO *If yes, how long?* _____

Did child have problems after birth (i.e. seizures, breathing, heart, etc...)? YES NO *If yes, explain:* _____

Any tests performed following birth? (i.e. MRI, CT Scan, EEG, etc...)? YES NO *If yes, explain, including dates:* _____

Was child transferred to another hospital after birth? YES NO *If yes, explain, including dates, length of stay, etc:* _____

Has child been diagnosed with vision and/or hearing problems? YES NO *If yes, explain:* _____

Does child have GERD (gastroesophageal reflux disease)? YES NO

Does child have any communicable (infectious/transmissible) disease(s), past or present YES NO *If yes, please explain & when was last active outbreak?* _____

At what age did your child *independently* do each activity listed below?

Milestone	Began at age:	Milestone	Began at age:
Bringing both hands to mouth		Self-dressing	
Grabbing a toy		Self-bathing	
Holding head up alone		Buttoning pants/shirt	
Rolling over		Zippering/unzipping jacket	
Sitting alone without support		Tying shoes	
Come to sitting from lying without assistance			
Creeping or crawling alone		Speech Milestones:	
Pulling self to a standing position		Babbling	
Standing unsupported		Saying first words	
Walking with support		Naming familiar objects	
Walking unaided		Putting 2 words together	
Fully toilet trained		Using short sentences	

Is there a family history of (*check all that apply*):

- ADD/ ADHD
- Allergies / Asthma
- Autism
- Birth defects
- Childhood deafness
- Learning disorder
- Mental health challenges
- Physical deformity
- Seizures
- Sickle cell
- Speech disorder

If yes, please describe: _____

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 4, 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

MEDICATIONS THAT CHILD CURRENTLY TAKES: Check if more than 3, then please provide separate list.

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

<p>Daily Behavior: Does child sleep well? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, please describe: _____ _____</p> <p>How often does child play: with other children? _____ with adults? _____</p> <p>How well is child doing in school? _____ _____</p> <p>Does the child have overreactions/under-reactions to objects/events that involve senses (hearing, feeling, touching, etc)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>How would you classify ease of discipline of child? <input type="checkbox"/> easy <input type="checkbox"/> average <input type="checkbox"/> hard</p> <p>What method of discipline works best for child? _____ _____</p> <p>Describe any perceived difficulty in concentrating by child: _____ _____</p> <p>Does child go from one toy/activity to another without stopping? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Does child have difficulty with change in routine? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Describe unusual behaviors (if any): _____ _____</p>
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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