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 FOR ALL THERAPY REFERRALS:

Name: ___________________________/____/__________________________
Last First Middle

Date of Birth: ____/____/______ Sex: □ Male □ Female

Mother's age at birth of child: _______ Father's age at birth of child: _______

FAMILY INFORMATION:

Is DSS involved with the care of this child: □ 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:	

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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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*: _________ & _________

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		Zipping/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: ____

____

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)	□ CDSA or □ 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

Daily Behavior:

Does child sleep well? □ YES □ NO
If no, please describe: ________________________________
____

How often does child play:

with other children? ________ with adults? _________

How well is child doing in school? ___________________
____

Does the child have overreactions/under-reactions to objects/events that involve senses (hearing, feeling, touching, etc)? □ YES □ NO

How would you classify ease of discipline of child?
□easy □average □hard

What method of discipline works best for child? _______
____

Describe any perceive difficulty in concentrating by child: ____

Does child go from one toy/activity to another without stopping □ YES □ NO

Does child have difficulty with change in routine?
□ YES □ NO

Describe unusual behaviors (if any): _________________
____

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

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