J.Z. MANN PEDIATRIC THERAPY

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On the questionnaire that follows, you are going to be asked for 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 possible is important.

Thank you and WELCOME to J. Z. Mann Pediatric Therapy!

PARENT QUESTIONNAIRE FOR ALL THERAPY REFERRALS:

Name: _____
Last First Middle

Birth date: _____/_____/_____ Sex: ☐Male ☐ Female Child's SS#: _____-_____-_____

Child's Diagnosis (*if applicable*): _____

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

FAMILY INFORMATION: Child lives with: ☐Mother ☐ Father ☐Other: _____
If other, specify: _____
_____

E-Mail address (**if checked daily**): _____

MOTHER	**FATHER**
Name (First Last):	Name (First Last):
Full Address:	Full Address: ☐ Same as Mother's
Home Phone: Cell Phone: Work Phone:	Home Phone: ☐ Same as Mother's Cell Phone: Work Phone:
Occupation: Employer:	Occupation: Employer:
Parents are: ☐ Married ☐Separated ☐ Divorced ☐ Widowed ☐ Unmarried	
Please specify languages, other than English, spoken in the home:	

If others are involved in the care of your child (daycare, neighbor, grandparents) please provide the following information:
(Please include this name on the Confidential Release if you would like us to be able to contact them)

_____

Name Relationship Phone#

If you have other children, please list:

Name: _____ Age: _____ Sex: ☐ Male ☐ Female

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Name: _____ Age: _____ Sex: ☐ Male ☐ Female

CHILD'S BIRTH/MEDICAL HISTORY:

How many weeks was pregnancy? _____ Birth weight: _____lbs _____oz
Delivering physician's name: _____ Hospital of Birth: _____
Length of labor:_____ Length of Delivery:_____ Was labor induced? ☐ Y ☐ N
Birth was: ☐ Natural ☐ Vaginal ☐ C-Section ☐ Emergency C-Section Apgar scores, *if known:* _____ & _____

Problems during pregnancy/labor/delivery: ☐ Y ☐ N *If Yes, explain:*	**Vacuum Extraction?** ☐ Y ☐ N **Forceps Used?** ☐ Y ☐ N **Was Child on Ventilator?** ☐ Y ☐ N **Did Child spend time in NICU after birth?** ☐ Y ☐ N *If yes, how long?*	**Did child have problems after birth (i.e. seizures, breathing, heart, etc…)?** ☐ Y ☐ N *If Yes, explain:*
Any tests performed following birth? (i.e. MRI, CT Scan, EEG, etc…)? ☐ Y ☐ N *If Yes, explain, including dates:*	**Was child transferred to another hospital after birth?** ☐ Y ☐ N *If Yes, explain, including dates, length of stay, etc:*	**Date or length of time after birth that child was discharged from hospital:** _____ **Has child been diagnosed with vision and/or hearing problems?** ☐ Y ☐ N *If Yes, explain:*

Has child had any of the following?	**Yes**	**No**	**Frequency**	**Treatment (What, When & Where)**
Frequent colds or allergies	☐	☐		
Ear aches/infections	☐	☐		
Running or draining ears	☐	☐		
Ear Tube Placement/Surgery	☐	☐		
Cancer	☐	☐		
Overreactions/under-reactions to objects/events that involve senses (hearing, feeling, touching, etc)	☐	☐		
GERD	☐	☐		

Does child have any communicable (infectious/transmissible) disease(s), past or present? ☐ Y ☐ N
If yes, please explain & when was last active outbreak?

PHYSICIAN INFORMATION: ☐ *Check if more than 3- then please provide separate list; Some examples: Neurologist (brain), Orthopedist (bone & joint), Cardiologist (heart), Ophthalmologist (eyes), etc.*
Please include these doctors on the Confidential Release of Information so we may obtain pertinent records.

Name	Specialty	Location (Clinic/Hospital etc.)	Last appointment	Next appointment
	Pediatrician			
	Other:			
	Other:			

SIGNIFICANT MEDICAL INFORMATION: Please list any allergies, seizures or major illness, injuries, or surgeries (include date, physician, location): ☐ N/A ☐ *Check if more than 3- then please provide separate list*

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

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

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

☐ ADD/ADHD ☐ Allergies/Asthma ☐ Autism ☐ Birth Defects

☐ Childhood Deafness ☐ Learning Disorder ☐ Mental Retardation ☐ Physical Deformity

☐ Seizures ☐ Sickle Cell ☐ Speech Disorder

If yes, please describe:

DEVELOPMENTAL HISTORY: [*Please fill out the Developmental History Addendum attached*]

OTHER SERVICES CHILD RECEIVES or HAS RECEIVED IN THE PAST 12 MONTHS:
Please include these providers on the Confidential Release of Information so we may obtain pertinent records.

Type of Service:	**Name of Agency/provider:**	**Frequency/schedule:**
Physical Therapy		
Occupational Therapy		
Speech Therapy		
ABA Therapy		
Infant Toddler Program	☐ CDSA or ☐ EDIS	Service Coordinator:
School Attending	Grade:	Does the child have a current IEP?: ☐ Y ☐ N Dates of IEP: _____ to _____
Has child had any psychological / behavioral testing? ☐ Y ☐ N *If yes, please describe (when, who did testing, results):*		
Has child had other medical evaluations such as (check all that apply): ☐ CDSA, ☐ EDIS, ☐ TEACCH, ☐ Cerebral Palsy Clinic, ☐ Muscular Dystrophy Clinic, ☐ AugCom, etc. **Other:** *If yes, please check all that apply and indicate date, place of evaluation, results:*		

Can you provide us with a copy of reports of the services listed above, including the IEP, if applicable? ☐ Y ☐ N
If no, ***please list the clinic/agency on the Confidential Release of Information so we may attempt to obtain copies for our records.***

Check all that apply: **Enrolled in ☐ EFMP / ☐ ECHO / ☐ CAP; ☐ N/A**
Name and contact information of Case Manager:_____
Community/Recreational activities child is involved in: _____

EQUIPMENT THAT CHILD HAS/UTILIZES: ☐ *Check if more than 3- then please provide separate list;*
Some examples: Braces for feet or hands, Wheelchair, Adapted stroller, Walker, Crutches, Bath chair, Potty chair, Ramp, hearing aid(s), AAC device, etc.

Type of equipment	**Name/Description of equipment (if known)**	**Date acquired**	**Date adjusted**

DAILY BEHAVIOR:
Does child sleep well? ☐ Y ☐ N
If no, please describe: _____

How often does child play:
With other children: _____*Age range of playmates:* _____

How does child "get along" with:
Other children: _____ *With adults:* _____

How well is child doing in school? _____

How would you classify ease of discipline of child?
☐ Easy ☐ Average ☐ Hard

What method of discipline works best for child?
_____

Describe any perceived difficulty in concentrating by child: _____

Does child go from one toy/activity to another without stopping? ☐ Y ☐ N

Does child have difficulty with change in routine? ☐ Y ☐ N

Describe unusual behaviors (if any): _____

Any concerns about child's eating and/or drinking? ☐ Y ☐ N If yes, p*lease explain any concerns about child's eating and/or drinking*:_____

How often (either # or schedule) does child eat/feed a day? _____

Ounces of formula at feeding? _____oz Time required to drink specified number of ounces? _____

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

Name of child's **primary** insurance company:	Sponsor's Name: _____ *If military, list rank:* _____ SS#:_____ DOB: ___/___/____ Relationship to child:	Policy #: Amount of Deductible: $ Has deductible been met? ☐ Y☐ N
Name of child's **secondary** insurance company:	Sponsor's Name: _____ *If military, list rank:* _____ SS#: _____ DOB: ___/___/____ Relationship to child:	Policy #: Amount of Deductible: $ Has deductible been met? ☐ Y☐ N

What is your flexibility to come to appointments? Are there certain days or times that you cannot come to appointments?

Please explain: _____

PLEASE READ THE FOLLOWING AND SIGN BELOW:

PARENT/GUARDIAN: If your child is recommended for therapy, it will be your responsibility to change your schedule or your child's schedule to attend available appointments. We will make every effort possible to work with you, but there are limited appointments available, particularly in the afternoon. Your child's therapy is important and attendance is necessary if your child is to progress.

I wish my child to be evaluated and/or treated by J.Z. Mann, Pediatric Therapy, Inc.
BY TYPING MY NAME BELOW, I AM PROVIDING AN ELECTRONICALLY SIGNED DOCUMENT THAT J.Z. MANN PEDIATRIC THERAPY, INC. IS AUTHORIZED TO USE.

_____ _____ _____
Signature Relationship to Child Date (mm/dd/yy)

Please complete the additional questions, provided on separate pages, for the therapy (therapies) that your child has been referred. *Once again, we thank you for choosing J. Z. Mann.*