

SAFE HOME PEDIATRIC PHYSICAL THERAPY

INTAKE SHEET

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Name: (Father) \_\_\_\_\_ (Mother) \_\_\_\_\_

Parent's Marital Status (Married, Single, Divorced, Widowed): \_\_\_\_\_

Home Address: \_\_\_\_\_

E-mail Address: (Father) \_\_\_\_\_ (Mother) \_\_\_\_\_

Please circle one: I DO I DO NOT consent to correspondence through email.

Phone: (Home) \_\_\_\_\_ (Father Cell) \_\_\_\_\_ (Mother Cell) \_\_\_\_\_

Father's Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Mother's Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

\*\*\*\*\*

Is there anyone involved in the routine payment or care of this patient with whom we may share medical information (caregivers, friends, extended family)? \_\_\_\_\_

Please check if you DO NOT consent to any of the following:

\_\_\_\_\_ I do not provide consent for messages to be left on my voice mail/answering machine.

\_\_\_\_\_ I do not provide consent for messages to be left with any other person in the household.

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialists: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

School/Program: \_\_\_\_\_ Phone: \_\_\_\_\_

School Therapists: \_\_\_\_\_ Time per week: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Diagnosis/Condition: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

**OVER**

Is this condition related to auto accident, other accident, or employment?.....Y            N

Do you have an attorney or advocate?.....Y            N

Does the child have an IEP/IFSP/504 Consult?.....Y            N

Gestational history: \_\_\_\_\_

Birth history: \_\_\_\_\_

Prior Hospitalizations/Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Equipment: \_\_\_\_\_

Vendor: \_\_\_\_\_ Phone: \_\_\_\_\_

Developmental Milestones (please indicate the approximate age when the child achieved the following):

Rolling \_\_\_\_\_ Sitting \_\_\_\_\_ Crawling \_\_\_\_\_

Standing \_\_\_\_\_ Walking \_\_\_\_\_

Is there anything you feel we should know that we have not asked? If yes, please explain:

\_\_\_\_\_

I, the undersigned, do hereby certify that I have understood and completed the above information and know it to be truthful and accurate to the best of my knowledge. I grant permission for designated personnel of Safe Home Pediatric Physical Therapy, LLC to provide the necessary treatment services for my child. I hereby assign Safe Home Pediatric Physical Therapy, LLC, all payments to which I am entitled for expenses related to the services performed and direct that payment for such services be made to Safe Home Pediatric Physical Therapy, LLC. This agreement will remain in effect until revoked by me in writing. A photocopy or facsimile of this document is to be considered as valid as an original. *I understand that I am responsible for full payment of all services rendered. I have been given the Notice of Patients' Rights and I consent to physical therapy treatment for my child. I have read and agree to the Safe Home Physical Therapy, LLC Policies and Procedures.*

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_