373 Blair Park Road, Suite 204, Williston, VT 05495
(P) 802-662-4672 (F) 802-662-5964
www.kidsrehabgym.org

New Patient Information Sheet

Patient Name _____

Patient date of birth:_____ SS#: _____

Parent name: _____ Email _____

Telephone number :_____ Alternative_____

Address: _____

Emergency contact (name)_____ (Number)_____

Primary Insurance:

Insurance company: _____ ID number: _____

Name of policy holder (or self): _____ Relationship to patient: _____

If not self:

DOB of policy holder _____

SS number of policy holder: _____

Employer of policy holder: _____

Address of policy holder (if different from patient): _____

_____

Secondary insurance:

❑ I do not have a secondary insurance (leave this section blank)

Insurance company: _____ ID number: _____

Name of policy holder (or self): _____

Physician information:

Referring physician: _____ date last seen: _____

Primary care physician: _____ date last seen: _____

I hereby authorize the Kids RehabGYM to release health care information necessary to file a claim with the above 3rd party payers and assign benefits payable to the Kids RehabGYM.

Guardian signature: _____ Date: _____

Name:_____
Preferred Name:_____
Preferred Pronouns: _____
Date of Birth:_____
Today's Date:_____

Please complete the following questionnaire to assist your OT/PT in developing the most appropriate rehabilitation program for your child. ***Thank you!***

Medical diagnosis and date:

_____

Please check all that apply:

❑Fractures/Sprains ❑Seizures/Epilepsy
❑Heart/lung Problems ❑Developmental Delay
❑Birth Complications ❑Cancer
❑Chronic Ear Infections ❑Repeated infection
❑Autism ❑Vision Problems
❑Tonsillectomy ❑Hearing Problems
❑Muscle Tone *Low High Varied*
❑Allergies _____
❑Surgeries_____
❑Other:_____

Your child's current medical team: (check all that apply)

❑ Primary care physician: _____
❑Orthopedist: _____
❑Neurologist: _____
❑ Physiatrist: _____
❑ Gastroenterologist: _____
❑ Cardiologist: _____
❑Pulmonologist: _____
❑Endocrinologist: _____
❑Developmental pediatrician: _____
❑Other: _____
_____

Is your child toilet trained? ❑Yes ❑No
Comments: _____

Does you child have any pain? ❑Yes ❑No
Location**:** _____
Pain Frequency: ❑ less than daily ❑ daily ❑constant
❑ night pain ❑ other _____

Is your child on any Medications? ❑Yes ❑No
If yes, list medications:_____

_____

Any family medical concerns? History of physical, emotional, speech, hearing, or learning problems in the family? Please describe: _____

_____

_____

Motivators, interests, sports, or hobbies: _____

_____

_____

Describe the problem(s) for which your child seeks therapy:

_____

_____

When did your current problem(s) begin? _____

Does your child have a PCA (Personal Care Attendant)? _____
Name: _____

Has your child received previous services?
❑ Yes (please check all that apply) ❑No

❑Occupational Therapy:
Initial Date: _____ Frequency: _____ Location_____
Name: _____
❑Physical Therapy:
Initial Date: _____ Frequency: _____ Location _____
Name: _____
❑Speech Therapy:
Initial Date: _____ Frequency: _____ Location_____
Name: _____
❑Hippotherapy:
Initial Date: _____ Frequency: _____ Location_____
Name: _____
❑Psychological treatment :
Initial Date: _____ Frequency: _____ Location_____
Name: _____
❑Other therapies: _____

School: _____
Does your child receive school services?
❑ Yes (please check all that apply) ❑No
Case manager: _____ contact: _____
❑Occupational Therapy:
Therapist:_____ contact: _____
❑Physical Therapy:
Therapist: _____ contact : _____

What other services does your child receive? (case management, ABA therapy, Howard services, 1 on 1 support, etc)

_____

Child lives with: (name and relation, please list all)

_____

_____

_____

Pregnancy and birth history:

Weeks gestation: _____

Any problems with mother/child health during pregnancy? _____

_____

_____

Any complications during delivery? _____

_____

Type of delivery: _____

Why? _____

Did the mother use any medications/substances during pregnancy? **(**including drugs/alcohol, cigarettes, antibiotics, sleeping pills, etc)

- ❑Yes : _____
- ❑ No
- ❑ Unsure

Did the child spend extra time at the hospital or in a special nursery?

- ❑Yes why? _____
- ❑ No

How did your child receive nutrition (ex. Breastfed, bottle fed, NG tube etc.)?

_____

Surgical History: (if applicable)

_____

_____

_____

_____

Can your child complete the following independently:

- ❑ tie a shoe
- ❑ put on socks
- ❑ button a shirt or pants
- ❑ snap pants
- ❑ zipper a coat
- ❑ brush teeth
- ❑ bathe or shower
- ❑ unscrew a lid
- ❑ climb the stairs
- ❑ ride a tricycle
- ❑ pump a swing

Hand dominance? ❑Left ❑Right ❑not decided

What age did your child complete the following:

	Age:
Roll over both ways	
Sit independently	
Crawl on hands and knees	
Cruise on furniture	
Walk	
Speak first word	
Drink from cup without lid	
Use a spoon	
Demonstrate hand preference	
Put on shirt	
Dress independently	

What are your child's strengths? _____

_____

What are your greatest concerns for your child relative to his/her development?

_____

_____

_____

Please comment on your child's behavior: _____

_____

_____

373 Blair Park Road, Suite 204, Williston, VT 05495
(P) 802-662-4672 (F) 802-662-5964
www.kidsrehabgym.org

Patient Agreement

PERMISSION FOR EVALUATION AND TREATMENT: I hereby give permission to the professional staff of the Kids' RehabGYM to perform any test(s) and give any treatment(s), deemed appropriate by the professional(s) responsible for my child's care.

TEAM APPROACH: The Kids' RehabGYM integrates the professions of Physical Therapy and Occupational Therapy in physical rehabilitation, injury prevention and general wellness. I understand that I may be treated by more than one of the Kids' RehabGYM's healthcare personnel over the course of care. I have the freedom to request an individual provider, but acknowledge that scheduling treatment visits may be more difficult. Your physical therapy evaluation and subsequent visits will be provided by a *Physical Therapist* who is licensed in the state of Vermont. Your occupational therapy evaluation and subsequent visits will be provided by an *Occupational Therapist* who is licensed in the state of Vermont.

RELEASE OF INFORMATION: I hereby authorize the Kids' RehabGYM to release any information necessary in coordination of my care to my insurance company(s), attending physician(s), school therapist(s), home based therapist(s), prior clinic therapist(s), current clinic therapists of other disciplines, and/or case manager(s).

PERSONAL PROPERTY STATEMENT: I hereby release the Kids' RehabGYM of any responsibility for the loss or theft of any personal items left in any section of the Kids' RehabGYM.

PAYMENT AGREEMENT: I permit the Kids RehabGYM to bill my insurance carrier directly and request any payments for service to be made directly to the Kids' RehabGYM. I certify the insurance identification information given by me is correct. I understand that I am responsible for and agree to pay **all** applicable copays, deductible amounts and charges not covered by my insurance at the time of treatment. If my obligations cannot be paid at the time of treatment, I agree to a payment schedule.

USE AND DISCLOSURE OF HEALTH INFORMATION: I have been shown and offered a copy of the Kids' RehabGYM **Uses and Disclosure of Information Statement**. I understand and accept the Kids' RehabGYM HIPAA compliant policy and know that I can contact Caitlin Cunningham (Executive Director) with any questions or concerns.

POOL USE: Our pools are specialty therapy pools, maintained to a higher standard of care than public pools. Due to these standards the following rules are required to use our pool: my child will be clean and free of open sores, my child will not use the pool if he/she is contagious with any illness (including excessively runny nose), and if there is a risk of bowel control issues, my child will wear a swim diaper. **If my child has an uncontained bowel or vomit incident in the pool I will be assessed a $75 fee for the first incident. A secondary incident will be assessed a $300 fee.**

NO SHOW/CANCEL POLICY

Attendance is important to both the quality of your child's rehab as well as the success of the Kids' RehabGYM business. Please cancel appointments at least 24 hours in advance. We understand last minute circumstances arise, but please ALWAYS call to let your therapist know if you will not be able to attend. **If your child is a no show or cancel (for reason other than illness) 30% of visits over 4 month period, you will lose scheduling priority! Further discussion with director required to discuss plan for therapeutic success of your child.**

Patient name:_____

_____ _____

Parent or guardian signature Date

I understand all statements made above and agree to its terms.

GROWTH THROUGH PLAY

373 Blair Park Road, Suite 204, Williston, VT 05495
(P) 802-662-4672 (F) 802-662-5964
www.kidsrehabgym.org

AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION

Patient Name:_____
Address: _____
_____

Date of Birth: _____

This will authorize **The KidsRehabGYM INC.** to ❑ **obtain** ❑ **release** a copy of my records regarding my medical diagnosis, treatment, and condition including, but not limited to, the following: *(check all that apply)*

❑ **Any / all deemed appropriate records**

❑ Records only for specific diagnosis(es) *(specify diagnosis(es):*_____

❑ Physician office records *(specify office(s):*_____

❑ Hospital records *(specify hospital):* _____

❑ School district, teacher, and therapist information *(specify):*

_____

❑ Other *(specify)*:

_____

_____

- ✓ I understand that all records obtained will observe all HIPAA confidentiality guidelines.
- ✓ I also understand that I have the right to inspect and request a copy of information to be disclosed and that I may withdraw this authorization at any time, except to the extent that action has been taken on this authorization.
- ✓ I understand that this authorization shall expire, without my express revocation, one year from the date written below.
- ✓ I understand there may be a fee involved for the reproduction costs of these records.

❑ Please mail records to: **The KidsRehabGYM Inc.**
373 Blair Park Road, Suite 204
Williston VT 05495
Phone: 802-662-4672

or FAX TO: 802-662-5964

_____ _____

Date ***Signature of the patient****, patient's legal guardian, or the patient's personal representative if the patient is deceased*

Witness:_____

Name *(please print)*:_____