



## PEDIATRIC PATIENT REGISTRATION

**This form MUST be completed LEGIBLY  
prior to initial treatment and annually, upon request**

Name:	Date of Birth:	Age:	Gender:
Parent(s) Name:	Physician's Name:		
SSN:	School and Grade:		
Phone Number:	Address, City & State:		
Cellular Number:	Email Address:		
Appointment Reminder Preference (please circle all that apply): Phone    Text    Email			
Emergency Contact (other than self) Name:		Number:	

### WHO IS FINANCIALLY RESPONSIBLE FOR TREATMENT (who holds the insurance policy)?

- Myself   
  My Spouse   
  My parent(s)   
  Other: \_\_\_\_\_

<b>Primary Insurance Company:</b>	<b>Secondary Insurance Company:</b>
<b>Policy/ID #:</b>	<b>Policy/ID #:</b>
Date of Birth (Policy Holder):	Date of Birth (Policy Holder):
SS# of Insured (Policy Holder):	SS# of Insured (Policy Holder):
Effective Date:	Effective Date:
Group Number:	Group Number:

Please initial beside each bullet after reading and sign below:

- \_\_\_\_\_ I certify the above is complete and accurate account of all medical insurance policies covering my child.
- \_\_\_\_\_ I consent to Integrity Rehab providing evaluation and ongoing therapy services. I understand that evaluation results and therapy recommendations are available to me upon request. Therapy services provided are Speech, Occupational and Physical Therapy.
- \_\_\_\_\_ I request that payment of authorized benefits be made on my behalf to this facility. I authorize the benefits payable to which I am entitled to this facility for services rendered. This authorization will remain in effect until revoked by me in writing. A photocopy and/or facsimile of this authorization is to be considered as valid as an original.
- \_\_\_\_\_ I understand that I am financially responsible for all charges whether or not paid for by said insurance (i.e. deductible amounts, co-insurance, co-pay, or any other balance not paid by my insurance). If this account is assigned to an attorney for collection and/or suit, the facility shall be entitled to reasonable attorney's fees and costs of collection.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## DEVELOPMENTAL HISTORY

### Background information:

full term pregnancy  premature birth - # of weeks \_\_\_\_ birth weight \_\_\_\_ lbs \_\_\_\_ oz

uncomplicated pregnancy  vaginal delivery  c-section

complicated pregnancy/delivery - details: \_\_\_\_\_

Length of hospital stay \_\_\_\_\_ Difficulties breathing after birth? Yes No

Any difficulties in the first two weeks of life? \_\_\_\_\_

List surgeries/hospitalizations (year/reason): \_\_\_\_\_

\_\_\_\_\_

Has your child ever had seizures? No Yes – type/frequency of seizures \_\_\_\_\_

\_\_\_\_\_

Please list **ALLERGIES** to food, medicine, or other: \_\_\_\_\_

Please list current **MEDICATIONS** (including over-the-counter, homeopathic, and herbal/vitamin supplements) \_\_\_\_\_

\_\_\_\_\_

Please list medical and psychological diagnoses: \_\_\_\_\_

\_\_\_\_\_

### At what age did your child (please complete with ages in months)

roll over \_\_\_\_\_ sit up independently \_\_\_\_\_ crawl \_\_\_\_\_ walk alone \_\_\_\_\_

babble \_\_\_\_\_ say first words \_\_\_\_\_ talk in phrases \_\_\_\_\_

feed self \_\_\_\_\_ dress self \_\_\_\_\_ toilet self \_\_\_\_\_

Please list any adaptive equipment your child uses: \_\_\_\_\_

Any movement restrictions? No Yes (detail) \_\_\_\_\_

### Hearing (please check box)

Normal hearing/no concern  Not tested  Hearing screened  BAER test

Full audiological evaluation  Hearing impaired  Hearing aid/s

Chronic upper respiratory infections (detail) \_\_\_\_\_

History of recurrent ear infections (detail) \_\_\_\_\_

History of “tubes” Past /Present (detail) \_\_\_\_\_

### Vision (please check box)

Normal vision/no concern  Not tested  Vision problem  Glasses/Contacts  Full vision evaluation

Vision therapy Details: \_\_\_\_\_

### Feeding/Swallowing (please check box) Feeds/drinks independently at age-appropriate level

Nursing  Difficulty with latch Uses:  bottle  sippy cup  regular cup  utensils

Problems with textures (list textures, i.e., crunchy, pudding-like) \_\_\_\_\_

Previous swallow studies (list date, risk of aspiration) \_\_\_\_\_

History of intubation (date, details) \_\_\_\_\_

History of g-tube (date, details) \_\_\_\_\_

History of scarring of esophageal lining (detail) \_\_\_\_\_

Problems with reflux (detail) \_\_\_\_\_

Takes supplements (list) \_\_\_\_\_

Please list diet restrictions: \_\_\_\_\_

**Communication Status (please check all that apply)**  points/gestures  signs  facial expressions

verbal (1-word)  verbal (2-words)  verbal (3-4 word phrases)  uses PECS  uses augmentative comm. device - Details: \_\_\_\_\_

**Child Profile Information** Lives with parents \_\_\_ Caregivers (name/s) \_\_\_\_\_

Siblings (names, ages) \_\_\_\_\_

Sleeps from (time) \_\_\_\_\_ to \_\_\_\_\_ Naps from (time) \_\_\_\_\_ to \_\_\_\_\_

How do you discipline your child? \_\_\_\_\_

Does child have a history of tantrums? No / Yes (detail) \_\_\_\_\_

Does child have a history of aggression? No / Yes (detail) \_\_\_\_\_

Child is best motivated by  stickers  food  praise  chart  coins  outing  other \_\_\_\_\_

Food likes: \_\_\_\_\_ Dislikes: \_\_\_\_\_

Attention span for self-directed activities: \_\_\_\_\_ Adult-directed: \_\_\_\_\_

Favorite TV shows/movies: \_\_\_\_\_

Favorite characters: \_\_\_\_\_

Child's unique characteristics: \_\_\_\_\_

**Availability**

Attends school M T W Th F (times) \_\_\_\_\_

Other therapy appointments (indicate time/day for each) PT \_\_\_\_\_ OT \_\_\_\_\_ ST \_\_\_\_\_ Other \_\_\_\_\_

Daycare/School (times) \_\_\_\_\_

Parent's/Caregiver's work schedule \_\_\_\_\_

Parent's/Caregiver's work schedule \_\_\_\_\_

Best therapy times \_\_\_\_\_ AM \_\_\_\_\_ PM

**Taste/Smell**

<b>Does child...</b>	Chew on non-food items (pencils, shirt, hair)?	Yes	No
	Demonstrate being an EXTREMELY picky eater?	Yes	No
	Have trouble eating different textured foods?	Yes	No
	Prefer spicy, sour, bitter tasting food flavors?	Yes	No
<b>Comments:</b>			

## Muscle Tone

<b>Does child...</b>	Have any diagnosed muscle problem?	Yes	No
	Have flat feet?	Yes	No
	Slouch when sitting on floor/chair?	Yes	No
	Get tired easily when playing or writing?	Yes	No
	Seem generally weak when compared to other kids?	Yes	No
	Keep mouth open when breathing?	Yes	No
	Appear uncoordinated?	Yes	No
<b>Comments:</b>			

## Fine Motor

<b>Does child...</b>	Have a dominant/preferred hand?	Yes	No
	Grasp toys?	Yes	No
	Color with crayons/markers?	Yes	No
	Take spoon/fork to mouth?	Yes	No
	Uses thumb/index to pick up small objects?	Yes	No
	Write name?	Yes	No
<b>Comments:</b>			

## Tactile (Touch)

<b>Does child...</b>	Dislike being held or cuddled?	Yes	No
	Constantly touch objects or intrude in others personal space?	Yes	No
	Seem easily irritated or enraged?	Yes	No
	Pinch, bite or otherwise hurt him/herself or others?	Yes	No
	Dislikes the feeling of fuzzy/furry clothing/textures?	Yes	No
	Over or under dresses for the temperature?	Yes	No
	Dislike having hair washed/cut or nails cut?	Yes	No
	Often seems unaware of food/liquid on lips?	Yes	No
<b>Comments:</b>			

## Vestibular (Movement)

<b>Does child...</b>	Like rough housing, jumping, crashing games?	Yes	No
	Like being tossed in the air?	Yes	No
	Spins or whirls more than other children?	Yes	No
	Get nauseous and/or vomit easily?	Yes	No
	Have fear in space (stairs/heights)?	Yes	No
	Lose balance easily?	Yes	No
	Walks on toes (not flat feet)?	Yes	No
<b>Comments:</b>			



## Cancellation and No-Show Policy

At Integrity Rehab, we strive to plan and develop specialized treatment based upon you or your child's needs. You or your child's attendance greatly impacts our ability to provide the best care that you or your child deserves. It is our policy to schedule patients in the following manner:

1. Provide a time that is the most convenient for the patient or their parents
2. Provide an appropriate clinician

Below is our cancellation policy:

- In order to provide your child the best care, sessions **MUST** start on time. If you arrive late you will only receive the remaining time for that therapy session. If you arrive more than 10 minutes late for your session we will have to cancel your appointment (exceptions will be made for emergency situations at the clinician's discretion).
- Any missed appointment (cancellation without 24-hours notice) will result in a \$25.00 fee. This fee **WILL NOT** be billed to your insurance company. The patient/primary caregiver is totally responsible for this fee.
- If a client has two (2) consecutive missed (cancelled with less than 24 hours notice) or no shows (not calling the clinic to inform canceling the session), will result in removal from scheduled therapy at Integrity Rehab. Further lack of communication after two weeks from last scheduled appointment will result in discharge from therapy.
- If a client has three (3) no shows (not calling the clinic to inform canceling the session) or missed appointments (cancelled with less than 24 hours notice) total within a **3-month period**, will result in removal from scheduled therapy or possible dismissal from therapy at Integrity Rehab.
- In extenuating circumstances, you may appeal to:

Pediatric Clinic Director: [kvenhuizen@integrityrehab.net](mailto:kvenhuizen@integrityrehab.net)

Adult Clinic Director: [achaney@integrityrehab.net](mailto:achaney@integrityrehab.net)

We treasure the ability to help you and/or your child progress and meet all of your/his or her goals. Please help us achieve these goals by cooperating with this policy.

Signature of Patient/Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_