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**Transforming Our Potentials**

3550 Parkwood Boulevard, Suite 704

Frisco, Texas 75034

Tel: 214-618-9341 Fax:214-619-9342

Toppediatricterapy.com

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**Biographical and Developmental Information**

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ yr. \_\_\_\_\_\_\_ mo. \_\_\_\_\_\_\_\_day

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_ yr. \_\_\_\_\_\_\_ mo. \_\_\_\_\_\_\_\_day

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Information:**

Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_Grade: \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_Grade: \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_Grade: \_\_\_\_\_\_\_\_\_\_

Current or ongoing concerns/reasons for referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information:**

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MOTHER’S HEALTH DURING PREGNANCY:**

Please circle Yes or No to the following questions and remark in the space provided.

1. Were there any infection/illnesses during pregnancy? Yes No
2. Was there any unusual stress during pregnancy? Yes No
3. Were any drugs or medications taken during pregnancy? Yes No
4. Was the pregnancy full-term? Yes No
5. Was the labor Normal? Yes No
6. Was delivery normal Yes No If no, please specify (cesarean section, breech, cord around neck, forceps used):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Was medication given during delivery? Yes No

**CHILD’S BIRTH**

Please circle all that apply and/or fill in the blanks

1. Child’s weight at birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Length of infant’s hospital stay:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Were there any complications? Seizures jaundice congenital defects Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Was there a need for: oxygen, transfusions, tube feeding, other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Did your infant cry right away?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Apgar scores: 1 min\_\_\_\_\_\_\_5 min\_\_\_\_\_\_\_\_\_\_\_\_
5. Was the child breast fed or bottle fed?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When weaned?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Did the infant have any feeding problems?
7. Describe your child’s behavior and demeanor as an infant:

**DEVELOPMENTAL MILESTONES:**

Please list the age (in months) at which your child did the following and answer the questions that follow.

Roll\_\_\_\_\_\_\_\_\_\_\_Sit\_\_\_\_\_\_\_\_\_\_\_\_Belly crawl\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Crawl on hand/knees\_\_\_\_\_\_ Walk\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Run\_\_\_\_\_\_\_\_\_\_\_ Skip\_\_\_\_\_\_\_\_\_\_\_\_\_ Say first word \_\_\_\_\_\_\_\_\_\_\_ finger feed \_\_\_\_\_\_\_\_\_\_ Use spoon\_\_\_\_\_\_\_\_

Drink from cup \_\_\_\_\_\_\_\_\_\_Dress independently\_\_\_\_\_\_\_\_\_\_\_Babble\_\_\_\_\_\_\_\_\_\_\_\_\_Put two words together\_\_\_\_\_\_\_\_\_\_

How many words does your child use now? 0-20 / 21-50 / 51-100 / 101-150 / 151-200 / 201-300 / 300+

1. Any concerns or questions about your child’s development? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. When did your child gain bladder control?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bowel control?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. How does your child ask for objects? Point Lead by hand Stand at fridge Pull shirt

Say what he/she wants Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is the primary language spoken in the home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Is there a family history of speech-language disorders or learning difficulties?

If so, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Can others outside the family understand your child when s/he speaks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How well does your child socialize with peers?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Does your child ever become frustrated when trying to speak or communicate his/her needs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. What helps your child reduce frustration?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**CURRENT CONDITION:**

Please circle all that apply and/or fill in the blanks.

Date of last physical exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Current weight\_\_\_\_\_\_\_\_\_\_\_\_Current height\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications/Dosage/Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My child currently sleeps/naps: inconsistently well restless other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My child currently eats/drinks: at regular/irregular intervals consistent/ inconsistent amounts

Known Allergies/Diet Restrictions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are immunizations up to date? Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of major illnesses/hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of ear infections? Yes No If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of most recent hearing test? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where was the test conducted? \_\_\_\_\_School \_\_\_\_\_\_Doctor \_\_\_\_\_\_\_Audiologist

Does your child wear hearing aids? Yes No Describe hearing loss:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of most recent vision screening: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where was the test conducted? \_\_\_\_\_School \_\_\_\_\_\_Doctor type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any vision impairment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does your child currently move in his/her environment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any diagnosed mental, physical or emothional disabilities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any concerns about physical, sexual , mental or emotional abuse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your child’s current demeanor/behavior \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREVIOUS & CURRENT THERAPIES AND/OR SPECIALISTS:** Please list names, types and dates seen. If applicable, please provide copies of relevant evaluations and reports (occupational therapy, speech-language, applied behavior analysis, psychoeducational, neurological, IEPs, etc…)

|  |
| --- |
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|  |

**SOCIAL HISTORY:**

School/Day Care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teacher’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Activities your child enjoys: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child prefer to do these activities alone or with other children/siblings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE USE SPACE BELOW FOR FURTHER COMMENTS:

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



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**Policy on Insurance Checks**

Per our accountant's advice, we have the following policy regarding filing a claim to your insurance   
company for out-of-network benefits:

1. Call your insurance company to see if they require you to use their claim form.

1. Be sure to include your policy ID number, patient's date of birth, and the primary insured's name   
   and date of birth.

3. Attach a copy of the invoice to the claim form and mail it to the address on your insurance card.

1. If you’re out-of-network benefits do not require that you reach a deductible first or if you have   
   already met your deductible, then it is also a good idea to attach a letter requesting payment be   
   sent directly to you.
2. If any payment is sent to TOP Pediatric Therapy, we will send the check back to the   
   insurance company, who must then reimburse the insured directly.



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**Fee Schedule (revised February 2013)**

**OCCUPATIONAL/SPEECH THERAPY TREATMENT** $30.00 per 15 minute unit

* individual treatment sessions are usually one hour in length
* the last 10 minutes will be used for caregiver/family consultation,

education and documentation

**OCCUPATIONAL/SPEECH THERAPY INITIAL EVALUATION** $500.00 flat fee

**OCCUPATIONAL AND SPEECH THERAPY INITIAL EVALUATION DONE AT SAME TIME** $400.00 flat fee

* this includes time spent assessing the child, interview with

caregiver/family, scoring of standardized assessments, formal

write-up, and discussion with caregiver/family

**OCCUPATIONAL/SPEECH THERAPY RE-EVALUATION** $300.00 flat fee

* re-evaluations typically occur every 6-9 months during the

regular treatment session and include time assessing the child,

scoring the assessments, documentation of short term goals, and

a formal write-up; consultation is not included

**CONSULTATION CHARGES** $30.00 per 15 minute unit

* this includes school visits, home visits, ARD’s, discussion/review

of re-evaluations and additional scheduled consultation in person

or by phone.

**CANCELLATION CHARGES AND OTHER FEES**

* if less than 24-hours notice OR no notice (“no show”): first cancellation No Charge
* if less than 24-hours notice OR no notice (“no show”): 2nd cancellation $60.00 per one hour appt.
* if less than 24-hours notice OR no notice (“no show”): 3rd or more cancellations $120.00 per one hour appt.
* if late to pick up your child from treatment $1.00 per minute

\*\*If “no shows” or cancellations reach 50% of scheduled sessions per months, treatment will be discontinued.

\*\*If missed therapy sessions are made up within 7 days no charges will be incurred. Sessions must be made up within normal business hours at the convenience of TOP Pediatric Therapists.

Please acknowledge that you have read and understand the above policies by signing below.

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

Parent or Guardian Signature Date



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**Patient Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Financial Responsibility**

* TOP Pediatric Therapy does not bill insurance.
* TOP Pediatric Therapy will provide you with billing slips to assist you in easy filing with your insurance company. On the 15th and at the end of the month, a billing slip will be provided for each date of service during the two week time period
* You are responsible for filing your own insurance. We will do our best to answer any insurance related questions. However, calling you insurance company directly is recommended
* You are responsible for all evaluation, treatment and consultation costs, regardless of insurance reimbursement. Payment in full is expected upon receipt of your bill or by the next scheduled appointment.
* You are responsible for payment for any and all cancellations. Please see the cancellation charges section on our fee schedule for specific details

I have read the above and hereby accept all responsibility for evaluation and treatment costs provided to my child. The undersigned certifies that he/she has been explained the evaluation and treatment costs and is the responsible party and accepts these terms.

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

Responsible party and/or trustee of patients funds Date

**Consent for Care and Treatment**

As the child’s parent or legal guardian, I hereby consent to necessary evaluation, procedures and/or treatments prescribed by my child’s therapist at TOP Pediatric Therapy as considered necessary in her or his judgment. I understand that various procedures and/ or treatments may be used, and I further understand that TOP Pediatric Therapy will make every effort to ensure that my child is safe during all procedures and / or treatments, but I acknowledge that injuries or accidents may still occur. I expressly agree that Top Pediatric therapy shall not be liable for any injuries or accidents sustained by my child while at Top Pediatric therapy. I understand that my child is under the care and supervision of his/her therapist.

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

Responsible party and/or trustee of patients funds Date

**Acknowledgement of Notice of Privacy Practices**

I acknowledge that TOP Pediatric Therapy will use and disclose my child’s personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law I further acknowledge that TOP Pediatric Therapy’s Notice of Privacy Practices, which is available upon request provide further detailed information about how TOP Pediatric Therapy may use and/or disclose protected medical information about my child for treatment, payment, healthcare operations, and as otherwise allowed by law.

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

Signature of legal representative of client Date



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Authorization to Release Medical Information

I hereby authorize TOP Pediatric Therapy to communicate all aspects of my child’s care with the physician(s) whom I have Identified:

Information can also be released to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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

For the purpose of \_\_\_\_\_Continued medical care/Coordination of care

\_\_\_\_\_Insurance Claims

\_\_\_\_\_Legal Matters

\_\_\_\_\_Other

This authorization is valid for the duration of my child’s therapy from the date signed below. I understand that I may revoke this authorization at any time, but will not hold any therapists working with TOP Pediatric Therapy responsible for already releasing information in good faith.

TOP Pediatric Therapy is released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

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

Parent or Guardian Signature Date



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Photograph and Video Release Form

TOP Pediatric Therapy is a private clinic focusing on the treatment of children and on the education of future therapist. As such, we may take photographs or videos of children or family members participating in treatment. The photographs and videos may include interviews, assessments, treatment, and/or other group activities. The rights, titles, and interests of these materials belong to TOP Pediatric Therapy, which reserves the right to edit the material.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(please print name) voluntarily consent to the taking of videos or photographs of myself or my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(print child’s name).

I understand that these photographs or videos may be used for educational purposes, treatment purposes, and/or medical purposes in educational training programs or media publications. I understand that the photographs or videos may be used to create educational training tapes and may be used by TOP Pediatric Therapy for seminars, staff/student training, workshops, on the TOP Pediatric Therapy website, and/or on television. Some video or photographic material may be included in future training tapes. Specific names of children and other family members may be used in photograph or videos.

I give permission for the use of photographs or videos for educational purposes, for news or other media for the TOP Pediatric Therapy website, and for training tapes.

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

Parent or Guardian Signature Date



**Transforming Our Potentials**

3550 Parkwood Boulevard, Suite 704

Frisco, Texas 75034

Tel: 214-618-9341 Fax:214-619-9342

Toppediatricterapy.com

**General Guidelines**

The following are general guidelines that will assist in creating a treatment environment that is as efficient and smooth as possible. If you have any questions, please speak with your child’s therapist.

1. Please have your child dressed in clothing that is easy to move in and is OK to get dirty.
2. If you want to observe the treatment session, please discuss this with your child’s therapist first. Observation is usually encouraged, but depending on the situation, it may be better if you are not present (for example, if your child has difficulty separating from you). Due to the HIPAA privacy laws, there is a specific procedure that must be followed to ensure the privacy of other clients in the treatment facility.
3. The last 10 minutes of the treatment session may be used for family education, discussion, and documentation. Please be present 10 minutes before the end of the scheduled session to allow for adequate discussion time. If you feel that you need additional discussion time, please schedule That time with your therapist, as this will prevent running late into the next appointment.
4. Please leave your contact information if you do not stay for the treatment session in case of any emergencies. Also, please be prompt in picking up your child when his/her session is over as we do not have the means for child care.
5. If you are running late for an appointment, please call to let us know.
6. If you must cancel an appointment, please do so by giving 24-hour notice. You will be allotted 1 occurrences of less than 24-hour notice or “no show” free of charge. Thereafter, the charge will be $60.00 per the second one-hour appointment cancelled or no showed. The third cancellation or “no show” will incur a $90.00 charge. The 4th and all subsequent cancellations will be charged a full session rate of $120.00 We do encourage rescheduling your appointment if possible, as it is essential to keep a regular schedule for the treatment to be successful. If missed or “no showed”
7. If no-shows or cancellations reach 50% of scheduled treatment sessions per month, treatment will be discontinued.
8. Payment in full is expected upon receipt of your bill or be the next scheduled appointment. If writing a check, please make it payable to Top Pediatric Therapy.
9. It is the client’s responsibility to file for insurance reimbursement. Top Pediatric Therapy does not directly bill insurance companies, but does provide you with a complete billing slip to make your filing easier. Please feel free to request any additional information that may assist you in your filing.
10. When possible, give two weeks notice of vacations and/or other times when your child cannot attend a scheduled treatment session.
11. You will be notified as far in advance as possible when your therapist is ill or otherwise unavailable. Every effort will be made to reschedule your appointment(s) so that your child will miss as little treatment as possible.

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

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Child’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Welcome to TOP Pediatric Therapy. We are looking forward to getting to know you and your child.

Please complete this form and bring it with you to your child’s first session. The therapist will review your responses and discuss your child’s treatment with you. Appropriate goals will be set in order to obtain the greatest overall benefits for your child.

What would you like to see accomplished during therapy? What would you like to see your child be able to do better?

Below, list any skills (i.e. jumping; tying shoes, handwriting, catching a ball) you would like you child to learn to do or do better. Beside the skill, circle the number (1-5) that best describes how your child is currently performing this skill.

1 = has never attempted because of fear of failure, or fear of activity.

2 = has attempted task, but prefers not to repeat it.

3 = likes to perform task, but becomes frustrated when success is not immediate.

4 = likes task, but continures to require assistance.

5 = average performance, but could use help to master the task.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 2 3 4 5

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 2 3 4 5

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 2 3 4 5

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 2 3 4 5

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 2 3 4 5

When your child is at the playground, is there any piece of equipment he/she prefers over the others?

Is there anything you would like us to reinforce while your child is in therapy?

Are there any situations/activities during your child’s day that are particularly challenging?

What type of behavior management works best for your child? Is behavior management an area of concern for you?

Let us know by listing below any type of diet restrictions or allergies your child may have. List below specific items you DO NOT want your child to have.

Is there anything else you would like to share with us about your child, in general?

How would you like for us to communicate with you? Please check below.

\_\_\_\_ **Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ **Scheduled conference times** (A separate fee will apply for conferences)

\_\_\_\_ **Informally, for approximately 10 minutes**, after the 50 minute session has ended.

What would you prefer your child to have as a treat at the end of the session? Circle one.

**CANDY STICKERS SMALL TOY Other, *something you will provide***

If someone else will be bringing your child to therapy most of the time, give us the name of the individual bringing your child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*General Guidelines for bringing your child to therapy:*

1. Be aware of our 24hr. cancellation policy.

2. Sessions are 50 minutes in length and will start and end on time. This allows for communication time with you following the session and allows the therapist time to record the session in your child’s chart before seeing her next patient.

3. During the initial evaluation session….

4. If you must run an errand during regular treatment time, please leave a cell phone number and plan to return prior to the end of your child’s session. CHILDREN ARE NOT TO BE LEFT UNATTENDED.

***The relationship we have with your child and your family is important to us.***

***At any time you have a question or concern, feel free to contact us, 214-618-9341***

**Sensorimotor History**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Each item below begins with “Does/Did the child” or “Is the child.” Please circle the best answer for each item. If there is not adequate room for your comments, please continue on the back. Thank you very much for taking the time to complete this history. It will help us greatly!

**TACTILE (touch)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.Like to be touched | Yes | No | Used to | N/A |
| 2. Dislike being held or cuddled | Yes | No | Used to | N/A |
| 3. Prefer to touch rather than be touched | Yes | No | Used to | N/A |
| 4. Seem excessively ticklish | Yes | No | Used to | N/A |
| 5. Seem easily irritated or enraged when touched | Yes | No | Used to | N/A |
| 6. Have a strong need to touch people and objects | Yes | No | Used to | N/A |
| 7. Seem to pick fights | Yes | No | Used to | N/A |
| 8. Pinch, bite or otherwise hurt self or others | Yes | No | Used to | N/A |
| 9. Frequently bump or push others | Yes | No | Used to | N/A |
| 10. Bang head on purpose | Yes | No | Used to | N/A |
| 11. Like to touch animals | Yes | No | Used to | N/A |
| 12. Dislike the feeling of certain clothing | Yes | No | Used to | N/A |
| 13. Over or under dress for temperature | Yes | No | Used to | N/A |
| 14. Overheat easily | Yes | No | Used to | N/A |
| 15. Seem overly sensitive to food or water temperature | Yes | No | Used to | N/A |
| 16. Seem overly sensitive to rough food textures | Yes | No | Used to | N/A |
| 17. Prefer tub baths over showers | Yes | No | Used to | N/A |
| 18. Like to play in water, sand, mud, clay, etc… | Yes | No | Used to | N/A |
| 19. Seem to lack the normal awareness to being touched | Yes | No | Used to | N/A |
| 20. Seem unaware of cuts, bruises, etc… until brought to attention | Yes | No | Used to | N/A |
| 21. Avoid using hands | Yes | No | Used to | N/A |
| 22. Examine objects or clothes with hands | Yes | No | Used to | N/A |
| 23. Mouth objects or clothes excessively | Yes | No | Used to | N/A |

**COMMENTS:**

**VESTIBULAR (movement)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Arch back when held or moved | Yes | No | Used to | N/A |
| 2. Enjoy being rocked | Yes | No | Used to | N/A |
| 3. Like being tossed in the air | Yes | No | Used to | N/A |
| 4. Like fast rides | Yes | No | Used to | N/A |
| 5. Like to swing | Yes | No | Used to | N/A |
| 6. Spin or whirl more than other children | Yes | No | Used to | N/A |
| 8. Get nauseous and/or vomit from other kinds of movement | Yes | No | Used to | N/A |
| 9. Rock/bounce while sitting | Yes | No | Used to | N/A |
| 10. Jump a lot | Yes | No | Used to | N/A |
| 11. Have fear in space (stairs, heights) | Yes | No | Used to | N/A |
| 12. Lose balance easily | Yes | No | Used to | N/A |
| 13. Walk on toes (rather than whole foot) | Yes | No | Used to | N/A |
| 14. Misunderstand meaning of words used in relation to movement or position | Yes | No | Used to | N/A |

**COMMENTS:**

**MUSCLE TONE:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Feel heavier than looks | Yes | No | Used to | N/A |
| 2. Have good endurance | Yes | No | Used to | N/A |
| 3. Have muscle problems | Yes | No | Used to | N/A |
| 4. Have flat feet | Yes | No | Used to | N/A |
| 5. Slump when sitting | Yes | No | Used to | N/A |
| 6. Tire easily | Yes | No | Used to | N/A |
| 7. Seem weak | Yes | No | Used to | N/A |
| 8. Keep mouth open | Yes | No | Used to | N/A |
| 9. Prefer lying on back | Yes | No | Used to | N/A |

**COMMENTS**

**AUDITORY (sound):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Have hearing loss | Yes | No | Used to | N/A |
| 2. Have (had) PE tubes | Yes | No | Used to | N/A |
| 3. Have (had) several ear infections | Yes | No | Used to | N/A |
| 4. Hypersensitive to sounds | Yes | No | Used to | N/A |
| 5. Afraid of unexpected noises | Yes | No | Used to | N/A |
| 6. Afraid of unusual sounds | Yes | No | Used to | N/A |
| 7. Distracted by sound | Yes | No | Used to | N/A |
| 8. Miss sounds or words | Yes | No | Used to | N/A |
| 9. Have trouble listening | Yes | No | Used to | N/A |
| 10. Have trouble locating sound | Yes | No | Used to | N/A |
| 11. Make loud noises | Yes | No | Used to | N/A |
| 12. Sing/dance to music | Yes | No | Used to | N/A |
| 13. Have trouble imitating rhythmic sounds | Yes | No | Used to | N/A |
| 14. Have trouble understanding or following directions | Yes | No | Used to | N/A |
| 15. Unable to follow 2-3 directions | Yes | No | Used to | N/A |
| 16. Talk excessively | Yes | No | Used to | N/A |
| 17. Talk such that it interferes with listening | Yes | No | Used to | N/A |
| 18. Have delayed speech | Yes | No | Used to | N/A |

**COMMENTS:**

**VISUAL:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Have a visual problem | Yes | No | Used to | N/A |
| 2. Seem very sensitive to light | Yes | No | Used to | N/A |
| 3. Have trouble using eyes | Yes | No | Used to | N/A |
| 4. Avoid eye contact | Yes | No | Used to | N/A |
| 5. Distracted by visual stimuli | Yes | No | Used to | N/A |
| 6. Dislike having eyes covered | Yes | No | Used to | N/A |
| 7. Able to close eyes for short periods | Yes | No | Used to | N/A |
| 8. Make reversals when writing, copying, reading | Yes | No | Used to | N/A |
| 9. Like playing in the dark | Yes | No | Used to | N/A |
| 10. Have trouble with shapes, colors, size | Yes | No | Used to | N/A |
| 11. Squint often | Yes | No | Used to | N/A |
| 12. Able to look far away | Yes | No | Used to | N/A |
| 13. Able to look close | Yes | No | Used to | N/A |

**COMMENTS:**

**TASTE AND SMELL:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Act as if all food is the same | Yes | No | Used to | N/A |
| 2. Explore with taste | Yes | No | Used to | N/A |
| 3. Chew on non food items | Yes | No | Used to | N/A |
| 4. Have any feeding problems | Yes | No | Used to | N/A |
| 5. Have trouble with changes in texture | Yes | No | Used to | N/A |
| 6. Hypersensitive to smells | Yes | No | Used to | N/A |
| 7. Taste or smell toys, clothes or foods more than peers | Yes | No | Used to | N/A |

**COMMENTS:**

**COORDINATION:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Sit, stand or walk late | Yes | No | Used to | N/A |
| 2. Sit, stand or walk early | Yes | No | Used to | N/A |
| 3. Have an omitted or short creeping or crawling phase | Yes | No | Used to | N/A |
| 4. Have a very long creeping or crawling phase | Yes | No | Used to | N/A |
| 5. Move in a slow, plodding, deliberate manner | Yes | No | Used to | N/A |
| 6. Play with toys appropriately for age | Yes | No | Used to | N/A |
| 7. Exhibit difficulty with dressing, buttoning, zipping, shoe tying | Yes | No | Used to | N/A |
| 8. Clumsy with toys | Yes | No | Used to | N/A |
| 9. Have trouble holding pencil correctly | Yes | No | Used to | N/A |
| 10. Creep on tummy or bottom | Yes | No | Used to | N/A |
| 11. Trip or fall a lot | Yes | No | Used to | N/A |
| 12. Seem awkward | Yes | No | Used to | N/A |
| 13. Bump into things | Yes | No | Used to | N/A |
| 14. Have poor handwriting | Yes | No | Used to | N/A |
| 15. Handle small items easily | Yes | No | Used to | N/A |
| 16. Eat neatly for age | Yes | No | Used to | N/A |
| 17. Have rigid movements | Yes | No | Used to | N/A |
| 18. Grimace or use tongue during fine motor tasks | Yes | No | Used to | N/A |
| 19. Seem shaky | Yes | No | Used to | N/A |
| 20. Enjoy sports, PE class | Yes | No | Used to | N/A |

**COMMENTS:**

**BEHAVIOR:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Quiet, calm, patient | Yes | No | Used to | N/A |
| 2. Active, outgoing | Yes | No | Used to | N/A |
| 3. Intense, anxious | Yes | No | Used to | N/A |
| 4. Explosive, aggressive | Yes | No | Used to | N/A |
| 5. Have a high activity level | Yes | No | Used to | N/A |
| 6. Easy going, predictable | Yes | No | Used to | N/A |
| 7. Have a low activity level | Yes | No | Used to | N/A |
| 8. Exhibit erratic sleep patterns | Yes | No | Used to | N/A |
| 9. Irritable as a baby | Yes | No | Used to | N/A |
| 10. Clingy | Yes | No | Used to | N/A |
| 11. Rigid, set in ways | Yes | No | Used to | N/A |
| 12. Adaptable, flexible | Yes | No | Used to | N/A |
| 13. Have regular sleep patterns | Yes | No | Used to | N/A |
| 14. Difficult to get to sleep | Yes | No | Used to | N/A |
| 15. Wake frequently | Yes | No | Used to | N/A |
| 16. Experience night terrors, nightmares | Yes | No | Used to | N/A |
| 17. Play alone well | Yes | No | Used to | N/A |
| 18. Destructive with toys | Yes | No | Used to | N/A |
| 19. Have short attention span | Yes | No | Used to | N/A |
| 20. Distractible | Yes | No | Used to | N/A |
| 21. Have difficulty making choices | Yes | No | Used to | N/A |
| 22. Engage in self-stimulatory behaviors | Yes | No | Used to | N/A |
| 23. Tantrum frequently | Yes | No | Used to | N/A |
| 24. Moody | Yes | No | Used to | N/A |
| 25. Experience difficulty with change | Yes | No | Used to | N/A |
| 26. Act out | Yes | No | Used to | N/A |
| 27. Make friends easily | Yes | No | Used to | N/A |
| 28. Prefer older children | Yes | No | Used to | N/A |
| 29. Prefer adults | Yes | No | Used to | N/A |
| 30. Prefer being alone | Yes | No | Used to | N/A |
| 31. Have a low self-esteem | Yes | No | Used to | N/A |
| 32. Frustrated frequently | Yes | No | Used to | N/A |
| 33. Seem discouraged or depressed | Yes | No | Used to | N/A |

**COMMENTS:**

**LEARNING STYLES:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Recognize own errors | Yes | No | Used to | N/A |
| 2. Learn from mistakes | Yes | No | Used to | N/A |
| 3. Acquire materials for task independently | Yes | No | Used to | N/A |
| 4. Able to set up work space | Yes | No | Used to | N/A |
| 5. Able to initiate or request | Yes | No | Used  To | N/A |
| 6. Requests for action to be repeated | Yes | No | Used to | N/A |
| 7. Responds to people within his or her workspace | Yes | No | Used to | N/A |
| 8. Tolerates people in his or her workspace | Yes | No | Used  To | N/A |
| 9. Exhibits joint attention | Yes | No | Used  To | N/A |
| 10. Greets- Hi/Bye | Yes | No | Used  To | N/A |
| 11. Understands letter-sound pairing | Yes | No | Used  To | N/A |
| 12. Maintain work space | Yes | No | Used to | N/A |
| 13. Work independently | Yes | No | Used to | N/A |
| 14. Generalize known skills to new ones | Yes | No | Used to | N/A |
| 15. Display age appropriate memory | Yes | No | Used to | N/A |
| 16. Ask for help when necessary | Yes | No | Used to | N/A |
| 17. Plan ahead | Yes | No | Used to | N/A |
| 18. Create new ideas, new ways of doing things | Yes | No | Used to | N/A |
| 19. Have age appropriate content in written language | Yes | No | Used to | N/A |
| 20. Get work done on time | Yes | No | Used  to | N/A |
| 21. Display average reading level | Yes | No | Used  to | N/A |
| 22. Display average math level | Yes | No | Used to | N/A |

**COMMENTS:**

**WAIVER AND RELEASE OF LIABILITY**

(Required for TOP PEDIATRIC THERAPY P.C. participation)

**I hereby release and covenant not-to-sue** TOP Pediatric Therapy P.C., and/or either entities officers and/or owners, their members, staff, volunteers, landlords, or agents**, from any and all present and future claims resulting from ordinary** **negligence on the part of TOP Pediatric Therapy P.C., or any others listed above** for property damage, personal injury, or wrongful death, arising as a result of engaging or receiving instruction in physical therapy, occupational therapy, feeding therapy, or any other activities or any activities incidental thereto, wherever, whenever, or however the same may occur. **I hereby voluntarily waive any and all claims resulting from ordinary negligence**, both present and future, that may be made by me, my family, state, heirs, agents, representatives or assigns.

I understand that TOP Pediatric Therapy P.C. activities involve certain risks, including but not limited to death, serious neck and spinal injuries resulting in complete or partial paralysis, brain damage, and serious injury to bones, joints, and muscles. Mats, pits, and other safety equipment and apparatus provided for protection, including the active participation of a therapist who will spot or assist in the performance of certain skills, may be inadequate to prevent serious injury.  **I am voluntarily allowing my child(ren) and/or myself to participate in this activity with knowledge of the risks involved and hereby agree to accept any and all inherent risks of property damage, personal injury, or death.**

I understand that this waiver is intended to be as broad and as inclusive as permitted by the laws of the state of Texas and agree that if any portion is held invalid, the remainder of the waiver will continue in full legal force and effect. I further agree that the venue for any legal proceedings shall be within the state of Texas.

**MEDICAL RELEASE**

Should my child(ren) and/or I become ill or injured while at TOP PEDIATRIC THERAPY P.C., I give permission and hereby grant the authority for TOP Pediatric Therapy P.C. staff members, or TOP Pediatric Therapy P.C. chaperones or volunteers, to (1) render first-aid emergenc y treatments **AND/OR** (2) to obtain emergency care for my child(ren) and/or myself; (3) to obtain the medical attention they may deem necessary for my child(ren) and /or myself. I further authorize the above designated to execute that consent required in connection with such advice or treatment. I hereby release said persons from and agree to indemnify them against any liability arising out of the exercise of the authority here granted.

The undersigned has read the foregoing “assumption of risk”, “waiver of liability”, “indemnification and hold harmless agreement”, “permission to treat and refer”, and “risks of athletic participation”, fully understands their terms, and understands that he/she is giving up substantial rights, including the right to sue. The undersigned acknowledges that he/she is signing the agreement freely and voluntarily.

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

Name (print)

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

Signature of Patient or Parent/Guardian (for minors) Date