Capable Kids
Pediatric Therapy | OT • Speech • PT

135 Snyder Road
Hermitage, PA 16148
Ph: 724-342-3898
Fax: 724-342-3949
www.capablekidsrehab.com

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**		
Custodial Parent/Guardian		☐ M ☐ F	**DOB:**		
☐ Mother ☐ Father ☐ Other		**Employer**			
Address					
Phone		**Email**			
Other Parent/Guardian		☐ M ☐ F	**DOB:**		
☐ Mother ☐ Father ☐ Other		**Employer**			
Address					
Phone		**Email**			

PERSONAL HISTORY

Other Responsible Adults				
Siblings				
Preferred Language		**School:**		**Grade:**

Please note any major changes in your child's life over the last 6-9 months and any other pertinent information.

Primary Insurance Information

Provider	
Member ID	
Group #	
Guarantor	
DOB	
SS#	
Address	

Secondary Information

Provider	
Member ID	
Group #	
Guarantor	
DOB	
SS#	
Address	

Reason for Referral

Referring Doctor	
PCP (if different):	
Reason for Visit	
Previous Diagnosis	
Previous Evaluations	
Current/Previous Treatment (list type and dates)	

Parent Guardian Observations

Your child's strengths	
Concerns about your child	
What do you hope will be gained by having your child seen at this clinic	

PREGNANCY/ BIRTH HISTORY

CHECK ANY OF THE FOLLOWING THAT APPLY AND GIVE EXPLANATION IF NEEDED			
Drank alcoholic beverages during pregnancy?	☐ Yes	☐ No	Explanation
Smoke?	☐ Yes	☐ No	Explanation
Take medication other than vitamins and iron?	☐ Yes	☐ No	Explanation
Use drugs?	☐ Yes	☐ No	Explanation
Have high blood pressure?	☐ Yes	☐ No	Explanation
Toxemia?	☐ Yes	☐ No	Explanation
Spotting or bleeding?	☐ Yes	☐ No	Explanation
German Measles?	☐ Yes	☐ No	Explanation
X-rays taken?	☐ Yes	☐ No	Explanation
Unusual physical strain or accident(s)?	☐ Yes	☐ No	Explanation
Prescribed bedrest?	☐ Yes	☐ No	Explanation
Unusual emotional strain?	☐ Yes	☐ No	Explanation
Illness/medical problems?	☐ Yes	☐ No	Explanation

CHECK YES OR NO IN REGARDS TO YOUR CHILD'S FIRST MONTH OF LIFE

Cyanosis	☐ Yes	☐ No		Which month of pregnancy did medical care begin?	☐ Yes	☐ No	
Jaundice	☐ Yes	☐ No		Jitteriness	☐ Yes	☐ No	
Injury	☐ Yes	☐ No		Trembling	☐ Yes	☐ No	
Floppy (poor muscle tone)	☐ Yes	☐ No		Stiff	☐ Yes	☐ No	
Failure to Thrive	☐ Yes	☐ No		Skin Rash	☐ Yes	☐ No	
Excessive Crying	☐ Yes	☐ No		Poor Suck/Swallow	☐ Yes	☐ No	
Feeding Difficulties	☐ Yes	☐ No		Congenital Anomaly	☐ Yes	☐ No	
Convulsions/Seizures	☐ Yes	☐ No		Diarrhea	☐ Yes	☐ No	
Infection	☐ Yes	☐ No		Anemia	☐ Yes	☐ No	
Colic	☐ Yes	☐ No		Allergies	☐ Yes	☐ No	
Heart Problems	☐ Yes	☐ No		Other Syndrome	☐ Yes	☐ No	

CHILD HEALTH HISTORY

Regular Medication (Please list)	☐ Yes	☐ No	Age		Explanation if yes	
Convulsion/Seizures	☐ Yes	☐ No	Age		Explanation if yes	
Meningitis	☐ Yes	☐ No	Age		Explanation if yes	
Encephalitis	☐ Yes	☐ No	Age		Explanation if yes	
Injury to Head	☐ Yes	☐ No	Age		Explanation if yes	
Fainting Spells	☐ Yes	☐ No	Age		Explanation if yes	
Measles	☐ Yes	☐ No	Age		Explanation if yes	
Chronic Illness	☐ Yes	☐ No	Age		Explanation if yes	
Constipation	☐ Yes	☐ No	Age		Explanation if yes	
Reflux	☐ Yes	☐ No	Age		Explanation if yes	
Allergies	☐ Yes	☐ No	Age		Explanation if yes	
Chronic Cough	☐ Yes	☐ No	Age		Explanation if yes	
Asthma	☐ Yes	☐ No	Age		Explanation if yes	
Heart Disorders	☐ Yes	☐ No	Age		Explanation if yes	
Stomach or Intestinal Disorders	☐ Yes	☐ No	Age		Explanation if yes	
Reaction to Immunizations (Specify)	☐ Yes	☐ No	Age		Explanation if yes	
Ear Infections	☐ Yes	☐ No	Age		Explanation if yes	
Hearing Exam/ Poor Hearing	☐ Yes	☐ No	Age		Explanation if yes	
Vision Exam/ Poor Vision	☐ Yes	☐ No	Age		Explanation if yes	
Sleep Disorders	☐ Yes	☐ No	Age		Explanation if yes	
Eating Disorders	☐ Yes	☐ No	Age		Explanation if yes	

ANSWER ONLY IF CHILD HAS ISSUES WITH FOOD/SWALLOWING

Describe typical foods and liquids consumed at each of the following:				
Breakfast:				
Lunch:				
Dinner:				
Quantity of liquids consumed daily				
What does your child drink from?	☐ Bottle	☐ Sippy Cup	☐ Regular Cup	☐ Other:
How does your child eat?	☐Spoon-fed	☐ Finger Foods	☐ Spoon	☐ Adaptive Equipment
Is your child a picky eater?	☐ Yes	☐ No	Does your child drool?	☐ Yes ☐ No
Does your child refuse any food tastes, textures, or temperatures?	☐ Yes ☐ No	If yes, please explain.		
Does your child suck their thumb/finger?	☐ Yes ☐ No		Does your child suck a pacifier?	☐ Yes ☐ No

ONLY ANSWER IF YOUR CHILD EXPERIENCES SOCIAL/EMOTIONAL DIFFICULTIES

Who generally disciplines the child?							
What are the methods used?							
Do all responsible parties agree on method(s) used?	☐ Yes	☐ No	If no explain:				

Check yes to all of the following that apply to your child, and please explain.

Difficult to discipline	☐ Yes ☐ No	Age		Explanation if yes		
Gets upset easily	☐ Yes ☐ No	Age		Explanation if yes		
Has temper tantrums	☐ Yes ☐ No	Age		Explanation if yes		
Bites nails	☐ Yes ☐ No	Age		Explanation if yes		
Sucks thumb	☐ Yes ☐ No	Age		Explanation if yes		
Has difficulty sleeping	☐ Yes ☐ No	Age		Explanation if yes		
Has nightmares	☐ Yes ☐ No	Age		Explanation if yes		
Wets bed	☐ Yes ☐ No	Age		Explanation if yes		
Is destructive	☐ Yes ☐ No	Age		Explanation if yes		
Prefers to be alone	☐ Yes ☐ No	Age		Explanation if yes		
Is unusually active, fidgety	☐ Yes ☐ No	Age		Explanation if yes		
Is unusually inactive, apathetic	☐ Yes ☐ No	Age		Explanation if yes		
Has unusual difficulty with brothers and/or sisters	☐ Yes ☐ No	Age		Explanation if yes		
Has unusual difficulty in getting along with other children	☐ Yes ☐ No	Age		Explanation if yes		
Inattentive	☐ Yes ☐ No	Age		Explanation if yes		
Compulsive	☐ Yes ☐ No	Age		Explanation if yes		

SOCIAL/EMOTIONAL DIFFICULTIES CONTINUED

Blames others for own mistakes	☐ Yes	☐ No	Age		Explanation if yes	
Lies	☐ Yes	☐ No	Age		Explanation if yes	
Steals	☐ Yes	☐ No	Age		Explanation if yes	
Excessive Absenteeism	☐ Yes	☐ No	Age		Explanation if yes	
Shows physical violence against persons or property	☐ Yes	☐ No	Age		Explanation if yes	
Has drug/alcohol abuse	☐ Yes	☐ No	Age		Explanation if yes	
Has anxiety	☐ Yes	☐ No	Age		Explanation if yes	
Has separation anxiety	☐ Yes	☐ No	Age		Explanation if yes	
Has headaches, stomach aches, nausea	☐ Yes	☐ No	Age		Explanation if yes	
Is often sad	☐ Yes	☐ No	Age		Explanation if yes	
Is self-conscious/ easily embarrassed	☐ Yes	☐ No	Age		Explanation if yes	
Avoids peer interactions or other unfamiliar social contacts	☐ Yes	☐ No	Age		Explanation if yes	
Has excessive concern with weight and/ or chronic eating	☐ Yes	☐ No	Age		Explanation if yes	
Has chronic motor and/or vocal tics	☐ Yes	☐ No	Age		Explanation if yes	
Has enuresis (wetting)	☐ Yes	☐ No	Age		Explanation if yes	
Has encopresis (soiling)	☐ Yes	☐ No	Age		Explanation if yes	
Has difficulties with transitions	☐ Yes	☐ No	Age		Explanation if yes	
Has self-injurious behavior	☐ Yes	☐ No	Age		Explanation if yes	
Has panic attacks	☐ Yes	☐ No	Age		Explanation if yes	
Has low productivity at school, work, and/or home	☐ Yes	☐ No	Age		Explanation if yes	
Is chronically tired/irritable	☐ Yes	☐ No	Age		Explanation if yes	
Has decreased interest in pleasurable activities	☐ Yes	☐ No	Age		Explanation if yes	
Has thoughts of death or suicide	☐ Yes	☐ No	Age		Explanation if yes	
Has hallucinations or delusions	☐ Yes	☐ No	Age		Explanation if yes	
Is socially inappropriate	☐ Yes	☐ No	Age		Explanation if yes	
Has odd/ bizarre ideas	☐ Yes	☐ No	Age		Explanation if yes	
Has poor personal hygiene	☐ Yes	☐ No	Age		Explanation if yes	
Is overly dependent/helpless	☐ Yes	☐ No	Age		Explanation if yes	

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided Capable Kids Notice of Privacy Practices ("Notice"):

- It tells me how Capable Kids will use my health information for the purposes of treatment, payment for my treatment, and Capable Kids health care operations.
- The Notice explains in more detail how Capable Kids may use and share my health information for other than treatment, payment, and health care operations.
- Capable Kids will also use and share my health information as required/permitted by law.

Patient's Complete Legal Name: _____
(Please print)

Patient's D.O.B. _____ Date: _____

Signature: _____
(Patient or legal representative)

Printed Name: _____
(Patient or legal representative)

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CLINIC POLICIES

Please read and sign the following policies. Keep one copy of this document for your records and return a copy to the office to be kept in the patient's file.

Consent for Treatment:
I hereby give my permission for Capable Kids to render treatment that is considered necessary and proper in diagnosing and treating my child's condition. I understand that I will be given all available and pertinent information prior to the treatment being rendered. I will be given the opportunity to ask questions and have them answered to my satisfaction. _____ (Initials)

Participation:
In order for your child to reach his/her established goals in their treatment plan, it is imperative that your child attend his/her regularly scheduled visit. We are aware that unanticipated emergencies (e.g. illness, family emergencies) take place. However, your child needs as much consistency as possible. ***We require an 80% attendance rate at their regularly scheduled time in order for them to continue to make progress.*** If appointments are not maintained on a consistent basis, we may move your child to a different treatment time or moved to our waiting list. _____ (Initials)

No Shows, Late Cancellations:
Our professional standard is to begin and end each session in a timely manner. Therefore, our expectation of our clients is that they will be punctual so that we are optimizing our appointments to the patient's benefit. Appointments follow a specific treatment plan for each patient. As such, patient's arriving more than 10 minutes late may be rescheduled and charged a late cancellation fee. Patients arriving more than 15 minutes late are considered No Shows, unless other arrangements have been made. Certainly we understand that there are exceptions to this policy, such as sick children and family emergencies, which are not possible to control. We simply ask that you be as mindful as possible of your therapist's schedule. Please note that it is your responsibility to contact the business office at the number above and leave a message after hours._____ (Initials)

No Shows:
Appointments that are not cancelled are considered a No Show. Patients arriving more than 15 minutes late for their scheduled appointment are considered No Shows. No Show appointments are charged the full out-of-pocket therapy rate. _____ (Initials)

Late Cancellations:
We request 24 hour notice for a cancelled appointment in order for our therapists to have the opportunity to adjust their schedule accordingly. An appointment that is not cancelled at least 2 hours prior to the scheduled appointment time is considered a late cancellation and clients will be charged a fee that equals half of the out-of-pocket therapy rate. _____ (Initials)

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Late Patient Pick-Up:
The late pick-up fee is $25.00 for every 15 minutes. Capable Kids cannot accommodate children that are left unattended as our therapists must go on to the next scheduled appointment. If you leave the clinic during the patient's session, please return five minutes prior to the conclusion of the session. We are mindful of those circumstances that are unavoidable. If an emergency occurs, please contact the business office as soon as possible so that the staff can make accommodations for the patient.
_____ (Initials)

Clinic and Waiting Room Manners
The care and safety of children and/or siblings that accompany you to your child's session are your responsibility. In addition, a patient's safety is the responsibility of the parent or guardian when not accompanied by a therapist. For their protection, children are not allowed in other areas of the building and are not permitted outside of the building unless escorted by a parent or guardian. Children in the waiting room are the responsibility of the parent or guardian. We ask that you please monitor your child in the waiting room and respect the property of Capable Kids and the other families in the reception area. We make every effort to keep our waiting room clean and tidy. If you bring snacks and/or drinks into the waiting room, please keep the area clean of any spills. We greatly appreciate the use of lidded cups. Please supervise your children in the restroom. _____ (Initials)

Refrain from using vulgarities, inappropriate language or unsuitable discussions in the waiting room. Be respectful of other parent and children around you. Keep your mobile phone calls to yourself and your phones silent. Smoking/vaping inside or outside the building is strictly prohibited. _____ (Initials)

Due to HIPAA regulations, we are not allowed to invite parents or guardians or siblings into the treatment area unaccompanied by a therapist and/or if another patient is being treated in the same area. Thank you in advance for your courtesy. _____ (Initials)

Acknowledgement and Assumption of Risk
I acknowledge and agree to have my child (or the child under my care), receive therapy services from Capable Kids. I acknowledge that there is some risk inherent in the use of the therapy equipment and I agree to assume such risk and indemnify and hold Capable Kids and its staff, harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child or our belongings.
_____ (Initials)

Medical Treatment Release:
In the event of an emergency situation at Capable Kids, I give the staff my permission to initiate emergency medical services for the child listed above if I am not present during the emergency.
Please note: If your child has any of the following conditions it is mandatory that you remain on the premises during his or her therapy session. These conditions include: Seizures, severe allergies, significant behavioral issues, and any condition that requires medicine to be controlled. This is for the safety of your child and the protection of our staff. _____ (Initials)

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Patient Release for Interns and Volunteer Staff

Capable Kids is a teaching and learning clinic, so on occasion student interns from various colleges may accompany your child's therapist, observe treatments, and have sight of their notes. A background check through each respective institution is conducted for each student intern. Capable Kids periodically allows volunteers to assist in the clinic. They may be in facility rooms with your child under the supervision of your child's therapist. Each volunteer has HIPAA privacy instructions. Volunteers are in place to learn and assist the therapist in the treatment of the patient and work for the benefit of patient's care. Volunteers are not employees of Capable Kids and cannot assist you with billing, scheduling, medical or insurance information. By signing, I understand that my child's treatment, testing, evaluations, daily notes and/or invoices will be seen by student interns in training to become Occupational Therapists, Occupational Therapy Assistants, Physical Therapists, Physical Therapy Assistants, Speech and Language Pathologists, Physician Assistants and by volunteer staff. I understand that the student interns and/or volunteers will be involved in the treatment of my child.

_____ (Initials)

Photo/Video/Website/Print Consent

I authorize Capable Kids to use my child's photo(s) in our brochures, printed materials, and in the clinic, and my child's photo(s) and/or video(s) on the website/social media platforms for the use of public relations, promoting various Capable Kids' therapy programs.

_____ YES (Initials) _____ NO (Initials)

Your signature below validates your initials on each of the clinic policies described above. We appreciate your time and effort in completing these forms. Accurate patient documentation is necessary for Capable Kids to protect our patients' rights.

_____ Patient Name

_____ Parent/Guardian's Name

_____ Patient's Signature (if over 18 years of age)

_____ Parent/Guardian's Signature

_____ Date

_____ Date

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COMMUNICATION CONSENT FORM

I give permission to Capable Kids to contact me in the following methods regarding my child's private health information, evaluation, treatment, and appointments. I authorize Capable Kids to leave messages for me when I am unavailable. You may receive an email or text three days prior to your appointment as a reminder. If you are not receiving this or in the correct amount of time, please let us know.

☐ Home Phone (_____) _____
☐ Message with Information ☐ Message with call-back number only

☐ Cell Phone (_____) _____
☐ Message with Information ☐ Message with call-back number only

☐ Work Phone (_____) _____
☐ Message with Information ☐ Message with call-back number only

☐ Text Messages (_____) _____
☐ Message with Information ☐ Message with call-back number only

☐ Email _____
☐ Message with Information ☐ Message with call-back number only

I authorize Capable Kids and therapists to discuss my health care information with the contacts listed below. I understand that by leaving these spaces blank, I am indicating that I do not want information released to anyone else.

Name	Relationship to Patient	Phone Number

By signing, I acknowledge that I have read and understand these communication guidelines. I allow Capable Kids to contact me by these means and give permission to the people listed above to receive patient health care information.

_____ _____

Patient, Guardian, Legal Representative Signature Date

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME (Last, First, MI)		Birthdate	
Address	City	State	Zip
Best Contact Phone	Other Phone		
Parent/Guardian Name	Relationship to Patient		
My signature below affirms that I am the legal guardian of the above listed patient, having full authority to request, receive and transfer Medical Health Records. I agree to take full responsibility for such records.			

I hereby authorize the use or disclosure of the above-mentioned patient's individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations

Release my child's protected health information to:

_____ _____

_____ _____

_____ _____

Request my child's protected health information from:

_____ _____

_____ _____

_____ _____

The patient or the client's representative must read and initial the following statements:

1. I understand that this authorization will expire one year after the signature date. Initials: _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have any effect on my actions they took before they received the revocation. Initials: _____

_____ _____

Signature of Patient or Patient Parent/Guardian Date

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

This form is not needed to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.

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Financial Agreement

Assignment of Insurance:
I authorize direct payment of medical benefits to Capable Kids. I understand that I am personally responsible to Capable Kids for any and all payments not covered by the insurance companies. Patients are billed for their annual out-of-network and in-network deductible at the beginning of their plan's calendar year. After the patient's out-of-network deductible has been satisfied, the patient is responsible for the co-pay amount set by their insurance carrier. Patients are billed for the remaining balance after payment has been received from their insurance company. Any non-covered services are the financial responsibility of the patient. In the event that payment for a performed service is denied by the insurance carrier, it is the patient's responsibility to pursue action with their insurance carrier, as the policy is a legal contract between the patient and the insurance company. Capable Kids is authorized to release any medical information required in the administering of applications for financial coverage for service required. _____ (Initials)

Verification of Insurance:
At Capable Kids, we will file with your insurance company as a courtesy. It is important for you to understand that when we contact your insurance company to verify benefits, they are only providing us with a quote. You should also call your insurance company to verify your benefits and check your benefits in your plan booklet. Many insurance plans have a limited number of visits for outpatient therapies. It is your responsibility to keep track of the number of visits your child has used. If you have participated in any therapy services with another provider during the insurance year, then you will need to include those visits. Capable Kids will do our best to keep track of these visits, but it is the parent's responsibility to manage the visits overall. This is especially important if the child is receiving additional services such as speech therapy, physical therapy, chiropractic care, etc. Verification of coverage is NOT a guarantee of payment. Benefits and payment will be determined by your insurance company once the claims are received. Any payments not covered by insurance or Medicaid will be the sole responsibility of the parent/guardian. _____ (Initials)

Medicaid as a Primary Insurance:
Capable Kids accepts most Pennsylvania Medicaid plans. Participation with recommended treatment plans is mandatory. *We report repeated cancelations, no-shows or discontinued services to Medicaid, which could result in the loss of your benefits.* _____ (Initials)

Secondary Insurance:
Capable Kids is required to submit all claims to the participants' primary insurance before submitting to a secondary insurance. We cannot submit claims to secondary insurance if the primary insurer denies authorization for treatment. If services are denied by the primary insurance, the patient is responsible for all charges incurred at the time of service. *If the secondary insurance is a Medicaid plan, we report repeated cancelations, no-shows or discontinued services to Medicaid, which could result in the loss of your benefits.* _____ (Initials)

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Change of Insurance Policy:
In the case of an insurance change (primary, secondary, or both) I agree to alert Capable Kids as soon as possible and to present them with my new insurance card(s) to copy for their records. I understand that failure to adequately inform Capable Kids of a change within a timely manner may result in my treatment being unpaid by my new insurance, particularly in the case that pre-authorization of treatment needed to be obtained, making me fully responsible for payment of those dates.
_____ (Initials)

Payments and Billing:
Payment for service is due at the time of each session. The individual who brings the patient to therapy is responsible for payment of the therapy session. Please make all checks payable to CAPABLE KIDS. An Automatic Credit Card Billing Agreement form must be completed in order to charge treatment sessions to your credit card. Copies of the credit card and the parent/guardian's driver's license must be on file with the completed Automatic Credit Card Billing Agreement. Please note, there will be a $40.00 charge for all returned checks and denied credit cards. _____ (Initials)

Out-of-pocket Payment:
If a patient does not have insurance or chooses not to submit claims to insurance they have the option of paying for service out-of-pocket. The patients are responsible for all charges incurred at the time of service. Fees for out-of-pocket services can be found on a separate fee schedule. _____ (Initials)

BY SIGNING THIS DOCUMENT, I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME OF SERVICE. I MUST PROVIDE A PHOTO COPY OF MY INSURANCE CARD ANNUALLY AND ANY TIME THAT I CHANGE INSURANCE PLANS. IT IS MY RESPONSIBILITY TO NOTIFY CAPABLE KIDS OF ANY CHANGES. I UNDERSTAND THAT I MAY BE RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY HEALTH PLAN WITHOUT LIMITATION OF THE OUT-OF-NETWORK DEDUCTIBLE, CO-PAYMENT AND/OR COINSURANCE AMOUNT. _____ (Initials)

Your signature below validates your initials on each of the clinic policies described above. We appreciate your time and effort in completing these forms. Accurate patient documentation is necessary for Capable Kids to protect our patients' rights.

_____ Patient Name

_____ Parent/Guardian's Name

_____ Patient's Signature (if over 18 years of age)

_____ Parent/Guardian's Signature

_____ Date

_____ Date