Amazing Kidz
Therapy, PLLC

New Client Demographic and Medical History Consent Form

Child's Name:	DOB:
Address:	Gender: M F
City, State, Zip Code:	Telephone:
Primary Physician:	Telephone:
Address:	

Parent/Guardian:	
Relationship to Child:	
Please provide your best contact phone numbers:	
Cell #:	Home/Other #:
Mailing Address:	
Email Address:	

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Relationship to Child:	
Please provide your best contact phone numbers:	
Cell #:	Home/Other #:
Mailing Address:	
Email Address:	

Insurance Information

Insurance Carrier:	Group ID:
Primary Holder Name:	Member ID:
Primary Holder SSN:	

Emergency Contacts

Although we never anticipate an emergency, in the event that there is an emergency and we are unable to reach the parents/guardians listed above, the below are individuals that Amazing Kidz Therapy may call regarding your child.

Name:	Phone:
Name:	Phone:
Name:	Phone:

Consent to Treat

I hereby authorize Amazing Kidz Therapy, PLLC and their therapists to perform evaluations and/or treatment to my child.

Parent/Guardian Signature: _____ Date: _____

Release of Information

I hereby authorize Amazing Kidz Therapy, PLLC to obtain and release information regarding my child to all listed insurance carriers. In addition, Amazing Kidz Therapy, PLLC may release and discuss information regarding my child, including but not limited to, evaluations, reports, progress notes and records, the following organizations, practices and individuals:

_____

_____

_____

_____

_____

_____

Emergency Care

In case of medical emergency, due to illness or injury during the process of receiving services, or while being on property, I authorize Amazing Kidz Therapy, PLLC to :

1. Secure, provide and retain medical treatment and transportation if needed.
2. Release client records upon request to authorized individual or agency involved in the medical emergency treatment.

Any and all costs for emergency medical care will be the responsibility of the parent/guardian of the child including, but not limited to transportation, urgent care and medical treatment.

Parent/Guardian Signature: _____ Date: _____

Financial Responsibility

All payment and co-pays are due at the time of services rendered. In the event that my insurance does not cover the services being rendered, I understand that I will become responsible for fees related to such services.

Parent/Guardian Signature: _____ Date: _____

Medical History

Pre-Natal & Birth History

Did the mother/child receive pre-natal care throughout the pregnancy? Yes No

Were there any notable complications during pregnancy? Yes No

If yes, please explain:

_____

_____

Delivery Method: Vaginal C-Section

Term of Pregnancy at the Time of Deliver in Weeks: _____

Complications immediately following delivery, including NICU and time in hospital:

_____

_____

Developmental Milestones

Please give the approximate age that your child preformed the below. If an event has not yet occurred, please denote with NA.

MILESTONE	AGE IN MONTHS	MILESTONE	AGE IN MONTHS
Smiled		Stood Alone	
Looked at Your Face		Walked	
Tracked Object with Eyes		Spoke First Word	
Ate Solid Food		Put Two Words Together	
Held/Picked Up Objects		Used Short Sentences	
Clapped Hands		Fed Self	
Rolled Over		Undressed Self	
Sat Alone		Dressed Self	
Crawled		Control of Bladder	
Held Own Bottle		Control of Bowels	

Diagnoses

Please list all diagnoses that have been given to your child and the approximate date in which they were made.

_____

_____

_____

_____

_____

Specialty Care

Please indicate if your child has ever been seen or evaluated by the following healthcare specialists.

SPECIALTY	PROVIDER	DATES	CURRENTLY IN THEIR CARE
Neurologist			Yes No
Cardiologist			Yes No
ENT			Yes No
Developmental Pediatrician			Yes No
Orthopedic			Yes No
Behavioral Specialist			Yes No
Occupational Therapist			Yes No
Physical Therapist			Yes No
Speech/Language Pathologist			Yes No

Surgeries/Hospitalizations

Please list any surgeries or hospitalizations, as well as dates, that your child has had.

_____

_____

_____

_____

Medications

Please list all current medication and dosage that your child currently takes.

_____

_____

_____

_____

Allergies

Please list any and all allergies that your child may have. If they and/or you carry an Epipen, please indicate that below.

_____

_____

_____

Sensory

Does your child have any hearing difficulties? □ Yes □ No

Does your child have any low vision difficulties? □ Yes □ No

Please list any sensitivities that your child may have (i.e. certain sounds that may cause distress):

_____
_____
_____