North Texas Therapy Innovations, P.C.

Patient Information

Patient's Name _____ Date of Birth _____ Gender _____

Preferred Name _____ Age _____

Marital Status of Parents _____ Pediatrician/Physician _____

Child lives with _____ Pediatrician Phone # _____

Siblings _____ Pediatrician Fax # _____

Any previous OT/PT/Speech treatment _____ If so, by whom, when & where _____

_____

Referred by _____ Reason for Referral _____

Any other medical issues/concerns to be known _____

Parent/Guardian Information

Responsible Party's Name _____ DOB _____ Relationship _____

Driver's License _____ State Issued _____ Email Address _____

Home # _____ Cell # _____ Work # _____

Home Address _____ City _____ State/Zip _____

Employer _____ Employer Address _____

Spouse's Name _____ DOB _____ Relationship _____

Driver's License _____ State Issued _____ Email Address _____

Home # _____ Cell # _____ Work # _____

Employer _____ Employer Address _____

Insurance Information Required

Insurance Company _____ Benefits/Claims Phone # _____

Address _____ Policy # _____

City/State/Zip_____ Group # _____

Name of Insured _____ Insured's DOB _____

Relationship to Patient _____

Authorized Person's Signature. I authorize payment of medical benefits to the undersigned provider for services rendered. I understand that NTTI files for the patient's primary insurance plan only as Out-of-Network providers. I further recognize that Secondary Insurance policies claims must be filed by the policy holder.

[ ] **FILE MY CLAIMS**

_____

Signature Date

[ ] **DO NOT FILE MY CLAIMS**

NORTH TEXAS THERAPY INNOVATIONS, P.C. CLINIC POLICIES

Please read and sign the following. Keep one copy for your records, and return a copy to the office to be held on file.

MISSION STATEMENT

We will create and provide exceptional services and treatments for our patients and their families, and strive to exceed their expectations by:

- *Encouraging and promoting excellence in the Practice of Occupational, Physical and Speech Therapy.*
- *Endorsing and supporting a high standard of ethical excellence.*
- *Striving for continuous innovative improvements in treatments.*

Please be respectful of all NTTI patients and parents, each child is a special work in progress and NTTI parents are all working to benefit their child's progress. _____ (initials)

TREATMENT SESSIONS

Half hour sessions of therapy are equal to 25 minutes of therapy. Forty-five minute sessions of therapy are equal to 35 minutes of therapy. One hour sessions of therapy are equal to 50 minutes of therapy.

Please be sure your child is dressed in gym clothes or comfortable play clothes for each therapy session. No hard soled shoes or high heels are worn in the gym (tennis shoes are fine.) Patient will go barefoot to have grounded footing on the equipment. _____ (initials)

PAYMENTS AND BILLING

Payment of services is due on the last session of each week when services are rendered. The person who brings the patient to therapy is responsible for the payment of the therapy session. Please make all **checks payable to NORTH TEXAS THERAPY INNOVATIONS**. A Credit Card on File Policy form must be completed in order to charge treatment sessions to your credit card. Credit Card on File Policy form must be completed when changing credit cards. A copy of the credit card and the parent/guardian driver's license must accompany the Credit Card on File Policy form. There will be a **$40.00 charge for all returned checks and denied credit cards.** Your Superbill provided at the time of service is your receipt. Statements are provided upon request only. **PAYMENTS AND BILLING POLICIES:** _____ (initials)

NO SHOWS, LATE CANCELLATIONS AND LATE PATIENT PICKUP

Our professional standard is to begin and end each session in a timely manner. Therefore our expectation of clients is to be punctual so that we are optimizing our appointments to patient's benefit. Appointments follow a specific treatment plan for each patient. Therefore patients arriving more than 10 minutes late may be rescheduled. Patients arriving more than 15 minutes late are considered NO SHOWS. There certainly can be exceptions to this policy, such as emergencies, sick children, etc. However it is your responsibility to contact your therapist as soon as possible to eliminate any extra fees.

Late Cancellations: Appointments not cancelled within 24 hours will be charged a fee of half of the scheduled session.

No Shows: Appointments not cancelled at all are considered a NO SHOW and are charged at the full rate of the scheduled therapy session.

Late Patient Pick Up: The late pick up fee is $36.00 per unit of time. NTTI cannot accommodate children left unattended. NTTI therapists **must** go on to the next scheduled appointment. Clients will receive one gentle warning/reminder regarding the Late Pick Up Policy. Subsequent late pickups will be firmly enforced by this policy. Thank you for your understanding and consideration.

Patient Name: _____

CANCELLATIONS ARE TO BE MADE DIRECTLY TO YOUR THERAPIST. EMAILS AND PHONE CALLS TO THE BUSINESS OFFICE ARE NOT RECOGNIZED. **NO SHOWS, LATE CANCELLATIONS AND LATE PATIENT PICKUP POLICIES:** _____ (initials)

CLINIC & WAITING ROOM MANNERS

Children in the waiting room are the responsibility of the parent or guardian. For your child's safety they are not allowed in other areas of the building unescorted. NO FOOD OR DRINKS ALLOWED IN WAITING AREA. Monitor your children in the waiting room and please respect the property of NTTI. We appreciate our waiting area neat and tidy. Thank you for assistance.

Please supervise your child in the restroom. We have low water pressure toilets – using too much toilet paper will block them. Additionally children are not allowed outside of the building without their parent/guardian. Patient and sibling safety is the responsibility of the parent/guardian when not accompanied by a therapist.

Due to HIPAA regulations, we are not allowed to invite parents/guardians or siblings into the treatment areas unaccompanied by a therapist and/or if another patient is being treated in the same area/gym.
CLINIC & WAITING ROOM MANNERS POLICIES: _____ (initials)

AUTHORIZATION FOR EMERGENCY CARE

This form is designed to meet legal requirements established in HB 1452, Acts of the 61st Legislature, Regular Session, which provides any person who has custody of a minor may give consent to medical care if the person has a signed affidavit by one or both parents authorizing the person to give consent.

In order to meet all the legal requirements, I hereby authorize representatives of **North Texas Therapy Innovations** or give consent for any necessary medical care for my child/children in said individual's custody. _____ (initials)

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternate means.

To help protect you and/or your child's PHI, please indicate the manner in which you would like to be contacted **(check all that apply)**

☐ **Home Phone Number:** _____
___ O.K. to leave message with detailed information
___ Leave message with call-back number only

☐ **Work/ Cell Phone Contact:** _____
___ O.K. to leave message with detailed information
___ Leave message with call-back number only

☐ **Written Communication**
___ O.K. to mail to my home address
___ O.K. to fax to this number : _____

PATIENT RECORD OF DISCLOSURES: _____ (initials)

Patient Name: _____

PATIENT RELEASE FOR INTERNS & VOLUNTEER STAFF

North Texas Therapy Innovations, P.C. is a teaching clinic, so from time to time we may have students from Texas Woman's University and Washington University accompany your child's therapist and observe treatment and have sight of their notes. Students are background checked through each respective institution.

North Texas Therapy Innovations, P.C. periodically allows volunteers to assist in the clinic. They will be in the gyms with your child under the supervision of an Occupational Therapist. Each volunteer has HIPAA Privacy instructions. Volunteers are in place to learn and assist the therapist in the treatment of the patient. Volunteers are not employees of North Texas Therapy Innovations, P.C. Volunteers cannot assist you in scheduling, billing, medical or insurance information.

By signing, I understand that my child's treatment, testing, evaluations, daily notes, and superbills will seen by Student Interns training to become Occupational Therapists and Volunteer Staff. By signing, I understand that the Student Interns and/or Volunteers will be involved in the treatment of my child.

PATIENT RELEASE FOR INTERNS & VOLUNTEER STAFF: _____ (initials)

FRAGRANCE FREE FACILITY

Please note that North Texas Therapy Innovations, P.C. is a perfume/cologne-free environment, due to sensitivities of patients and staff. _____ (initials)

FINANCIAL AGREEMENT

Aenta, BC/BS, and UNITEDHEALTHCARE PATIENTS: NORTH TEXAS THERAPY INNOVATIONS, P.C. files insurance claims as an out-of-network provider with the above listed insurance companies. Patients are billed for their annual out-of-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 the insurance carrier. Patients are billed for any remaining balance after payment has been received from the insurance company. Any non-covered services are the financial responsibility of the patient.

In the event that payment for a service performed 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. _____ (initials)

OTHER CARRIERS, NO INS. COVERAGE: If a patient has insurance carriers other than those listed above or has no insurance coverage, they are responsible for all charges incurred at the time of service. **Co-payments, co-insurance, non-covered services and/or deductibles are the responsibility of the patient and are payable at the time of service.** _____ (initials)

JOINT CUSTODY PAYMENT POLICY: NTTI no longer divides out credit card payments for children of divorced parents. NTTI's clinic policy requires the parent/guardian who brings the child in for services to be financially responsible for the payment of treatment services rendered. NTTI cannot be involved in billing issues between divorced and/or separated parents/guardians. Parents may pay separately by check. Payment must be made in full. Credit card payments are only allowed by the custodial parent. Only signatures of the cardholder present at the appointment are allowed. There are no exceptions to this policy.

_____ (initials)

BY SIGNING THIS, I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME OF SERVICE. I MUST PROVIDE A PHOTO COPY OF MY INSURANCE CARD ANNUALLY AND ALSO AT ANY TIME MY INSURANCE PLAN CHANGES. IT IS MY RESPONSIBILITY TO NOTIFY NORTH TEXAS THERAPY OF ANY CHANGES THAT AFFECT THE BILLING PROCESS. I UNDERSTAND THAT I MAY BE RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY HEALTH PLAN WITHOUT LIMITATION OF THE OUT-OF-NETWORK DEDUCTIBLE, COPAYMENT/COINSURANCE AND/OR OUT-OF-POCKET MAXIMUM VISTITS/AMOUNTS. _____ (initials)

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practice from North Texas Therapy Innovations, P.C. I have read this notice and am aware of my rights and obligations. _____ (initials)

Signing below validates your initials on each of the above clinic policies. Thank you for your time in completing these forms. Accurate patient documentation allows NTTI to protect the patient's rights.

Elizabeth (Betty) McBride, Clinical Director, OTR, SIPT Certified
North Texas Therapy Innovations
11886 Greenville Ave, Suite 110
Dallas, Texas 75243

Phone 214-349-6178
Fax 214-575-9898
www.sensorytherapydallas.com

Patient Name	Parent Name/Guardian
Home Address	
Patient Signature *(if over 18 yrs of age)*	Parent Name/Guardian Signature
Date	Date

Patient Name: _____

North Texas Therapy Innovations, P.C.

Clinic Wellness Policy

Please do not bring your child (patient or sibling) into the clinic if they are exhibiting any of the following medical health concerns:

FEVER
Fevers are common in young children and are often a signal that something is wrong. If your child has a fever of 101.0 F or higher, please keep him/her at home. If your child develops a fever of 101.0 F or higher while at the clinic the therapy session will end and your therapist will make every reasonable effort to reschedule.

Our policy is that your child must remain free of fever for 24 hours before returning to the clinic, and area pediatricians agree with this policy. This means that if your child had a fever at 1 a.m. in the morning he/she would not be able to attend a 10 a.m. scheduled therapy appointment. The 24 hours begins when your child's fever has broken and remains in the normal range.

DIARRHEA
Diarrhea due to illness is highly contagious. If you child has diarrhea, please keep him/her home. Please understand that germs from diarrhea can spread through carpet, toys, swings and direct contact. It is very difficult to keep from spreading these germs to other children.

VOMITING
If your child vomits while at the clinic, you will be called immediately to pick him/her up. Please keep your child at home until 24 hours after the vomiting has stopped. When children come to therapy too soon, there is a much higher rate of recurrence and contagiousness.

THE COMMON COLD
These include but are not limited to: bad cold with hacking or persistent cough, green or yellow nasal drainage, productive cough with green or yellow phlegm being coughed up. These symptoms may be present with or without a fever.

RASH
A rash may be a sign of many illnesses, such as measles or chicken pox. Please do not bring your child into the clinic until your doctor says it is O.K. to do so.

We do understand and empathize with parents when their children are ill. These policies are designed to be fair to the ill child and their family as well as to our healthy children and their families. Please understand that we love your children and provide the best possible care for them. We are hoping to control the amount of illnesses at the clinic and to keep everyone healthy and happy. If you ever have any questions or concerns, please do not hesitate to call.

We wish to express our sincere thanks to all of you who keep your sick little ones at home and comply with our policies. We appreciate your courtesy!

_____
Patient Name (Please Print)

_____ _____
Parent/Guardian (Please Print) Date

North Texas Therapy Innovations
Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. *Please review this carefully*.

If you have any questions about this notice, please contact the Facility Privacy Officer by calling our office number.

Who Will Follow These Practices?

Protected Health Information (PHI) will be disclosed by NTTI and therapists.
These policies do not apply to information that NTTI and therapists receive while in a non-health care provider capacity.
These require NTTI, employees, and any third parties that participate to comply with the privacy rules while engaging in other activities.
NTTI employees providing services are required to protect each patient's PHI. This is information we have created or received relating to health conditions, all of the health care payments that identify you or provides basis to believe the information can identify you.
PHI does not include individually identifiable information contained in the Family Education Rights and Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA).
We provide you with this notice to explain how, when, and why we disclose your PHI. We will not disclose any more than is necessary.
We reserve the right to change the terms of this notice at any time that will apply to what we already have. We will make the change in this notice and post a new one at our location and on the website.
NTTI is required to notify affected individuals in the case of any breach of their unsecured PHI.

How We May Disclose and Use Your Protected Health Information

Certain uses and disclosures do not require your authorization for these reasons:
For Treatment-It may also be disclosed to educational facilities, your referring physician, and those participating in the delivery of health care.
For Payment-It may be disclosed so your services are billed and payment is collected properly. We may tell the clinic about treatment to be received to obtain prior approval and determine if your plan covers treatment. We may discuss PHI with a pharmacist as well to determine correct dosage and administration of medical information.
For Health Care Operations-It may be disclosed to review services to evaluate the performance of the staff and make sure all patients receive quality care. We may combine the PHI of several patients to determine if additional services need to be offered, which services are not needed, and if treatments are effective. Identifiable information may be removed for educational facilities to use.
When Disclosure Is Required By Law-Under HIPAA, we must make PHI disclosures to the Secretary of the Department of Health and Human Services if the law requires us to do so. It is for them to investigate our compliance with the requirements of the Privacy Rule with HIPAA.
For Public Health Activities-It may be disclosed if information is reported about births, deaths, various diseases, etc. to government officials collecting this information. Information will also be provided to necessary medical providers.
For Health Oversight Activities-It may be disclosed to a health oversight agency for activities authorized by the law. This is necessary to assist government conduction of investigation or inspection of a health care provider or organization.
For Research Purposes-It may be disclosed to approved researchers with reviewed and accepted protocols. This will include no unique identification of the subject of the information.
To Avoid Harm-It may be disclosed when we believe it will prevent a serious threat to the health and safety of a person or the public. We may provide PHI to law enforcement able to prevent or lessen harm.
For Specific Government Function-It may be disclosed for military personnel or veterans for intelligence, counter-intelligence, and national security purposes.

For Workers compensation Purposes-It may be disclosed to comply with these laws that benefit work-related injuries or illnesses.

Appointment Reminders and Health-Related Benefits-It may be disclosed for reminders and give information about treatment alternatives or services we offer.

Inmates-It may be disclosed about an inmate or the person having lawful custody. This is necessary to provide them with health care, protect their and others health and safety, and provide law enforcement on institution premises.

To You and Your Personal Representative-It may be disclosed to your representative if you are a minor. We will obtain documentation that supports your representation prior to disclosure. We do have the right not to accept this person if we have reason to believe they are a danger to you in some form.

Uses and Disclosures with Prior Written Authorization:

In situations not referenced above, we will ask for written authorization before using or disclosing your PHI. If you choose to authorize PHI disclosure, you can later revoke the authorization in writing to stop any further disclosure.

What Rights You Have Regarding Your PHI

To See and Get Copies of Your PHI-The request must be made in writing and we will respond to you within 30 days of receiving it. We may deny the request in writing in certain situations. We may charge a fee for copying, mailing or supply costs.

To Correct or Update Your PHI-If you think there may be a mistake or information is missing, you may submit a request in writing to change it and we will respond to it within 60 days. We may deny it if the PHI is complete and correct, not created by us, not allowed to be disclosed, or is not part of our records. If we approve it, we will make the change, tell you that we have, and make sure others know.

To Get a List of the Disclosures We Have Made-We will respond within 60 days of your written request. This list will include disclosures made in the last 6 years unless you request a shorter time. It includes the date of disclosure, to whom it was disclosed, description of the information, and the reason for disclosure.

To Request Limits on Uses and Disclosures of Your PHI-A written request must be submitted to NTTI. It must tell us the PHI you would like to limit, the reasons why, and to whom the limits apply. We will consider this request but are not legally required to accept it.

To Choose How We Send PHI to You-You can request that we send information to an alternate address or by alternate means. We must agree to this request as long as it is reasonable and can easily provide the requested information. It must be submitted in writing to NTTI.

To Get a Paper copy of This Privacy Notice-Request must be submitted or you may look on our website for a copy at www.sensorytherapydallas.com

How to Complain About Our Privacy Practices

If you think we may have violated your privacy rights or you disagree with a decision made about access to your PHI, you may file a complaint with the NTTI Privacy Officer. We will take no retaliatory action against you if you file a complaint about our Privacy Practices.

_____ _____

Signature of Patient or Personal Representative **Date**

North Texas Therapy Innovations
11886 Greenville Ave, Suite 110
Dallas, TX 75243

Communication Consent Form

I give permission to NTTI to contact me in the following methods regarding my private health information, evaluation, treatment, and appointments. I authorize NTTI to leave messages for me when I am not available.

☐ 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 NTTI 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 NTTI 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

NORTH TEXAS THERAPY INNOVATIONS, P.C.

CREDIT CARD AGREEMENT

North Texas Therapy Innovations, P.C. can process your payment via Master Card & Visa both Credit & Debit cards and personal checks. **SORRY, WE CANNOT ACCEPT DISCOVER & AMERICAN EXPRESS.**

We ask you to pay us promptly. Payment is due upon receipt of your invoice (Encounter Form) at the end of each week of treatment. It is your responsibility to keep a copy of your Encounter form for your records. You may choose to have us charge your credit card at the end of each week for services rendered. Once you authorize NTTI to charge your credit card for services rendered, your charges will automatically be processed each week according to the services rendered. **If you choose to discontinue Automatic Credit Card Services, it is your responsibility to notify the Main Business Office of NTTI in writing.**

We at NTTI are diligent to protect your privacy. Therefore, this document will remain at the Business Office in Dallas. Your therapists will not have access to this document so if you need to make changes, please contact the NTTI business office at 214-349-6178.

Thank you,
North Texas Therapy Innovations, P.C.

CREDIT CARD PAYER: **Patient:** _____

I **agree** to have North Texas Therapy Innovations, P.C. charge my credit card weekly for therapy services rendered. A $40.00 fee will be charged for inactive/declined credit cards.

_____ Name of Cardholder as it appears on the card

Card Type: ☐Master Card ☐Visa **SORRY, WE CANNOT ACCEPT DISCOVER & AMERICAN EXPRESS**

Credit Card #: Please print clearly!

Exp. Date: (ex: 04/10)

		/		

Security #: (last 3 digits from back of the Card)

Credit Card Holder's Billing Address:

_____
Address

_____ _____ _____
City State Zip

_____
Cardholder / Responsible Party Signature Date

For Office Use Only:
Date Business Office Received forms: _____ Received by: _____

Sensory Motor History

(Some of these questions may not reflect the age of the person you are describing skip these if they don't pertain to your child. You may add narrative on the back to be more specific on your child)

Mothers Health History

(Is child adopted? _____ If so at what age? _____ From what country? _____)

1. Infections/Illness during pregnancy YES NO
Describe_____
2. Have any shocks or abnormal stresses during pregnancy YES NO
Describe_____
_____
3. Did the Mother's Water break 24 hours before delivery YES NO
4. Develop Toxemia or high blood pressure YES NO
When?_____
5. Have any Complications during delivery and or Labor YES NO
_____
6. Mother's age at Delivery _____Length of Pregnancy_____
7. Number of Miscarriages _____Premature how many weeks_____
8. What was the child's birth weight _____Child's weight a discharge from Hospital _____
9. Apgar Scores 1 minute_____ 5 Minutes_____

Child's Birth

	Yes	No	
1.	____	____	Full term?
2.	____	____	Premature?
3.	____	____	Cesarean section?
4.	____	____	Require petocin?
5.	____	____	Breech (feet first)?
6.	____	____	Face presentation?
7.	____	____	Transverse (sideways)?
8.	____	____	Have cord wrapped around neck?
9.	____	____	Require forceps?
10.	____	____	Have any birth injuries?
11.	____	____	Require a fetal monitor?
12.	____	____	Have insufficient oxygen?
13.	____	____	Cried right away?
14.	____	____	Require intensive care/hospitalization? ~~~ If so, how long? _____
15.	____	____	Respiratory problems?
16.	____	____	Need a respirator? ~~ If so, how long? _____
17.	____	____	Small for gestational age?
18.	____	____	Heart defect?
19.	____	____	Require an exchange transfusion?
20.	____	____	Jaundiced? ~~~ If so how long? _____
21.	____	____	Have any congenital abnormalities?
22.	____	____	Have seizures?
23.	____	____	Have any infections at birth?
24.	____	____	Have any surgery at birth? ~~ Describe: _____
25.	____	____	Have any feeding problems at birth? ~~ Describe: _____

Patient Name : _____

Taste and Smell

	YES	NO	USED TO	
1.	___	___	_____	Act as though all food taste the same
2.	___	___	_____	Avoid and crave certain foods. ~ Describe: _____
3.	___	___	_____	Chew on non-food items
4.	___	___	_____	Have any feeding problems ~ Describe: _____
				_____
5.	___	___	_____	Have any trouble changing to textured food
6.	___	___	_____	Sensitive to unusual smells
7.	___	___	_____	Taste or smell toys, clothes etc. –more than usual

Muscle tone

1.	___	___	_____	Feels heavier than he looks
2.	___	___	_____	Have good endurance
3.	___	___	_____	Have any diagnosed muscle problem
4.	___	___	_____	Have flat feet
5.	___	___	_____	Slump when sitting
6.	___	___	_____	Get tired easily
7.	___	___	_____	Seem generally weak
8.	___	___	_____	Keep mouth open
9.	___	___	_____	Prefer to lie on back rather than tummy as infant

Coordination and Development

1.	___	___	_____	Was creeping and crawling phase unusually prolonged
2.	___	___	_____	Are movements slow, plodding, deliberate
3.	___	___	_____	Have difficulty with sequential tasks (such as Dressing, buttoning, Zippering, shoe tying (circle the ones the child is having problems with))
4.	___	___	_____	Have difficulty learning to hold a pencil/crayon in a mature grasp
5.	___	___	_____	Creep on tummy or bottom
6.	___	___	_____	Clumsy Playing with toys
7.	___	___	_____	Trip or fall often
8.	___	___	_____	Seem clumsy or awkward
9.	___	___	_____	Bump into thing often
10.				Which hand is dominant: _____
11.	___	___	_____	Have poor handwriting
12.	___	___	_____	Eat neatly for age
13.	___	___	_____	Have rigid movements
14.	___	___	_____	Hand gets shaky in fine motor movements
15.	___	___	_____	Enjoy sports or gym, etc.

Childs age for independent: Sitting _____ Crawling _____
Standing _____ Walking _____

Auditory

1.	___	___	_____	Have a diagnosed hearing problem
2.	___	___	_____	Have frequent ear infections.
3	___	___	_____	Require Tubes in ears? ~Are they still present?_____
4.	___	___	_____	Seem sensitive to sound
5.	___	___	_____	Respond negatively to unexpected sounds
6.	___	___	_____	Have fear of any particular sounds. Describe _____

Patient Name : _____

Auditory (continued)

	YES	NO	USED TO	
7.	____	____	_____	Distracted by sounds such as refrigerator, fans, heaters, and fluorescent bulbs
8.	____	____	_____	Seems to be confused about what direction sounds come from
9.	____	____	_____	Likes to make loud noises
10.	____	____	_____	Have difficulty repeating rhythmical sounds
11.	____	____	_____	Fail to follow through to act upon requests to do something
12.	____	____	_____	Unable to function if 2 or 3- part commands are give at once
13.	____	____	_____	Talks excessively
14.	____	____	_____	Talking interferes with listening
15.	____	____	_____	Have a Speech or Language delay

Tactile

1.	____	____	_____	Likes to be touched
2.	____	____	_____	Dislikes being held or cuddled
3.	____	____	_____	Prefers to touch rather than be touched
4.	____	____	_____	Seems excessively ticklish
5.	____	____	_____	Seems easily irritated or enraged when touched by siblings or playmates
6.	____	____	_____	Have strong need to touch objects and people
7.	____	____	_____	Seems to pick fights
8.	____	____	_____	Pinch, bite, or otherwise hurt himself or others
9.	____	____	_____	Frequently bump or push others
10.	____	____	_____	Bangs head on purpose
11.	____	____	_____	Dislike the feeling pf certain clothing
12.	____	____	_____	Over or under dress for the temperature
13.	____	____	_____	Overheat easily
14.	____	____	_____	Seems overly sensitive to food or water temperature
15.	____	____	_____	Seems overly sensitive to different food textures~Describe_____
16.	____	____	_____	Prefer tub baths over showers if given a choice.
17.	____	____	_____	Likes to play in water, sand, mud, clay
18.	____	____	_____	Seems to lack the normal awareness of being touched
19.	____	____	_____	Often seems unaware of cuts, bruises
20.	____	____	_____	Avoids using their hands
21.	____	____	_____	Examine objects or clothes with his hands
22.	____	____	_____	Walks on toes
23.	____	____	_____	Dislikes haircuts or nail trimming
24.	____	____	_____	Chews on objects or clothes

Vestibular

1.	____	____	_____	Arch back when held or moved as an infant
2.	____	____	_____	Enjoy being rocked
3.	____	____	_____	Liked being tossed in the air
4.	____	____	_____	Like fast spinning carnival rides
5.	____	____	_____	Like to swing
6.	____	____	_____	Spin or whirl more than other children
7.	____	____	_____	Get carsick easily
8.	____	____	_____	Get nauseous and or vomit from other movement experiences
9.	____	____	_____	Rock while sitting

Patient Name : _____

Vestibular (Con't)

	YES	NO	USED TO	
10.	____	____	_____	Jump a lot
11.	____	____	_____	Have fear of space (Stairs, heights, crawl tunnels)
12.	____	____	_____	Lose balance easily
13.	____	____	_____	Misunderstand the meaning of words used in relation to movement & direction

Visual

1.	____	____	_____ Have a diagnosed visual problem
2.	____	____	_____ Seem very sensitive to light
3.	____	____	_____ Have trouble following with their eyes
4.	____	____	_____ Avoid eye contact
5.	____	____	_____ Distracted by visual contact
6.	____	____	_____ Dislike having eyes covered
7.	____	____	_____ Able to close eyes for short periods of time
8.	____	____	_____ Make reversals when copying or reading
9.	____	____	_____ Prefer playing in the dark
10.	____	____	_____ Have trouble discriminating shapes, colors
11.	____	____	_____ Squint often
12.	____	____	_____ Able to look at something far away
13.	____	____	_____ Able to look at something close
14.	____	____	_____ Blink or turn face away when a ball is thrown at them

Behavior or Temperament

1.	____	____	_____ Calm or relaxed
2.	____	____	_____ Active, outgoing, enthusiastic
3.	____	____	_____ Intense, easily frustrated, anxious
4.	____	____	_____ Explosive
5.	____	____	_____ Cry excessively in infancy
6.	____	____	_____ Clingy
7.	____	____	_____ Rigid, set in his ways
8.	____	____	_____ Adaptable, flexible
9.	____	____	_____ Regular sleep patterns
10.	____	____	_____ Difficult to get to sleep
11.	____	____	_____ Wakes frequently
12.	____	____	_____ Screams when wakes during night
13.	____	____	_____ Short attention span
14.	____	____	_____ Distractible
15.	____	____	_____ Demonstrate self-stimulating behaviors ~ Describe: _____
16.	____	____	_____ Display extreme mood changes
17.	____	____	_____ Unable to adjust to routine change
18.	____	____	_____ Express feelings of failure and frustration
19.	____	____	_____ Express feeling of low self-esteem
20.	____	____	_____ Does seem discouraged or depressed

Patient Name : _____

School- Aged Children Only

	YES	NO	USED TO	
1.	____	____	_____	Recognizes own errors
2.	____	____	_____	Learns from mistakes
3.	____	____	_____	Acquire materials he needs for a task
4.	____	____	_____	Able to set up a workspace
5.	____	____	_____	Maintain work space
6.	____	____	_____	Able to work independently
7.	____	____	_____	Generalize know skills to acquire new skills
8.	____	____	_____	Ask for help appropriately
9.	____	____	_____	Plan ahead
10.	____	____	_____	Comprehends age appropriate content in written language
11.	____	____	_____	Gets work done on time
12.	____	____	_____	Average reading level _____
13.	____	____	_____	Average Math level _____
14.	____	____	_____	I. Q. (This is confidential)
15.	____	____	_____	Current placement in school

This is Case history is compiled and adapted from A.J. Ayres, Ph.D., Patricia Wilbarger, Med, OTR, Montgomery/Richter, 1977, Knikerbocker and Jo Murphy Nyland.