KIRSCH THERAPY

PATIENT INFORMATION

Child's Name: _____Male/Female_____
Date of Birth: _____
Address: _____
_____
Email: _____

Phone Number: _____

Cell Number: (Mother) _____
(Father)_____

Mother's Name: _____
Address: (if different) _____
_____
Date of Birth: _____ SSN: _____
Driver's License: _____ State: _____
Employer: _____
Work Number: _____

Father's Name: _____
Address (if different) _____
_____
Date of Birth: _____ SSN: _____
Driver's License: _____ State: _____
Employer Name: _____
Work Number: _____

Insurance Carrier: _____
Policy Number: _____
Insured's Name: _____

Primary Care Physician: _____
Physician's Phone Number: _____

Referred By: _____

1949 Avenida del Oro, Suite 118, Oceanside, CA 92056 Phone (760) 945-6500 Fax (760) 945-6535
www.kirschtherapy.com

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Patient Name:_____ D.O.B._____

EVALUATION QUESTIONNAIRE

1. What is your concern with your child's development? Check all that apply:
   - ☐ Speech/communication Explain:_____
   - ☐ Feeding/eating/drinking Explain:_____
   - ☐ Dressing/bathing/toileting Explain:_____
   - ☐ Behavior/emotional regulation Explain:_____
   - ☐ Coordination Explain:_____
   - ☐ Other Explain:_____

2. How much of your child's speech do you understand? _____% How much do other people understand? _____% Is there a family history of speech delay? Y/N Who:_____
   Nature of problem_____
   _____

3. Were there any complications with pregnancy? Y/N Explain: _____
   _____ How many weeks gestation was the pregnancy?_____Did you have a C-Section? Y/N Why? _____
   What was your baby's APGAR scores?_____Birth weight? _____

4. Did your child require any special care following birth? (Oxygen, intensive care, tube feeding, etc.) Was your child admitted to the N.I.C.U. in the hospital? Y/N Explain: _____
   _____

5. Did your child have any difficulty breastfeeding? Y/N Explain: _____
   _____

6. When did your child first roll over? _____ Sit up unsupported?_____, Crawl?_____, Walk? _____, Say 1st words? _____

7. Does your child often trip/fall/injure his/herself? Y/N Explain_____
   _____

8. Did your child take a bottle? Y/N How long? _____ Did your child use a pacifier? Y/N How long? _____ Suck their thumbs/fingers?_____

9. Has your child had his/her vision checked? Y/N Were the results Normal/Abnormal? When? _____ Hearing checked? Y/N Were the results Normal/Abnormal? When?

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Patient Name:_____ D.O.B._____

_____ Where? _____Dental Visit Y/N Dental Work?_____
_____

10. Has your child had any ear infections? Y/N How many? _____ Does he/she have tubes? Y/N When? _____

11. Are your child's immunizations up-to-date? Y/N Explain if "no" _____
_____

12. Is your child taking any medications Y/N, Vitamins Y/N, or homeopathic remedies? Y/N Explain _____

13. Has your child ever been hospitalized, had surgery or a major accident? Y/N When & Why?_____

14. Does your child have allergies? Y/N To what? _____

15. Has your child been diagnosed with ADHD, ODD, PDD, Autism, Seizures, Dyslexia, Learning Disability, Mental Retardation, Hearing Loss, Developmental Delay or any other illness, disease or syndrome? Y/N Explain _____
_____
_____

16. Is there a family history of ADHD, ODD, PDD, Autism, Seizures, Dyslexia, Learning Disability, Mental Retardation, Hearing Loss, Developmental Delay or any other illness, disease or syndrome? Y/N Who and what? _____
_____

17. Are there any other languages spoken in the home? Y/N What language?_____
How often_____ By whom _____

18. With whom does the child live?

Name: Relationship: Age:

_____
_____
_____
_____
_____

19. Are there custody issues? Y/N What are the arrangements?_____
_____

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20. Does your child attend preschool, school or daycare? Y/N Where? _____
    How many days per week?_____
    How is your child's academic performance? Do you have any concerns?
    Explain:_____
    _____

21. How are your child's social skills with peers? Do you have any concerns? Explain:
    _____
    _____

22. Is/has your child enrolled in any other therapies or programs (C3, ABA, Floor time, HOPE, PT, OT, Speech, Vision therapy, Psychological, or any other program)? Y/N
    What? _____
    Where? _____

23. Is your child a picky eater? Y/N Does he/she eat a good variety of fruits, vegetables and meats? _____Does he/she seem sensitive to certain textures? Y/N
    Explain:_____ Does he/she over-stuff, gag, spit out, or cough when eating or drinking? Y/N Explain: _____

24. Does your child have any food allergies or sensitivities? Y/N Explain_____
    _____

25. Does your child eat the same meal as the rest of the family? Y/N
    _____

26. Does your child display any quirky, unusual or repetitive behaviors? Y/N Explain:
    _____

27. Do you have any behavioral or other concerns? Y/N Explain_____
    _____
    _____

28. Do you have any other concerns? Y/N_____
    _____
    _____

KIRSCH THERAPY

RELEASE OF INFORMATION

This release form allows the exchange of information between two parties. Please complete this form if you (the parent/legal guardian) would like a copy of your child's medical reports from Kirsch Therapy. This form can also be used to allow Kirsch Therapy to exchange information about your child's treatment program with another person (teacher, grandparent, another therapist/agency, etc). Do not fill this out for your primary care physician, but do note any other physician you would like included in your child's care (e.g. ENT, allergist, etc.). This release is valid for one year and may be cancelled in writing at any time.

I hereby authorize: _____
Name of facility or person to release the information.

To release: _____
Type of records or information to be released.

For: _____
Patient's name

Date of Birth: _____

To: _____
Name of Person or Facility to Receive Records

_____
Address or Fax Number

_____
City, State, Zip Code

Date: _____ Patient/Guardian Signature: _____

Relationship: _____ Witness: _____

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Patient Name: _____ Date of Birth: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Many patients allow family members, care givers, or other individuals to discuss aspects of their medical circumstances and conditions (test results, procedures, medications, appointments, etc.) Under HIPPA regulations, we cannot give patient personal health information to individuals other than the patient without the patient's written consent. If you wish to have your or your child's medical information released to other individuals, please complete the section below. This authorization will allow **Kirsch Therapy** to release information only to those individuals listed below. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on prior consent.

I authorize **Kirsch Therapy** to release my or my child's medical circumstances and conditions, including but not limited to: goals, progress and test results, to the following individuals:

1. _____ Relationship to Patient_____ Phone#:_____

2. _____ Relationship to Patient_____ Phone #:_____

This authorization covers all medical information prior to and up to one year after the date this Authorization is signed.

PATIENT/PARENT SIGNATURE: _____DATE_____

AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS

From time to time it is necessary representatives of **Kirsch Therapy** to leave messages for patients. The purpose of the messages is to remind patients of an appointment, notify the patient of test procedure results, or to ask the patient, parent or legal guardian to call the office regarding an issue or concern. At no time will a representative discuss your medical circumstance or condition without your consent. **The purpose of this consent is to authorize us to leave messages with members of your household or on your answering machine at home or at work. Please indicate below the phone numbers where we may leave messages with those who answer the telephone or leave a message on the answering machine or voice mail.**

You have the right to revoke or change this consent at any time, in writing, except where we have already made disclosures in reliance on your prior consent.

Home # _____ CELL # _____ WORK # _____

PATIENT/PARENT SIGNATURE: _____ DATE_____

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CONSENT TO TREAT

1. _____The undersigned consents to the treatment which will be provided during therapy, evaluations and treatments.
2. _____The undersigned understands that as part of healthcare, health records describing health history, symptoms, test results, diagnoses, treatment, and recommendations for future care, treatment and referrals will be generated. How this information can be disclosed including for treatment, payment and health care operations is described by the Health Insurance Portability and Accountability Act (HIPAA).
3. _____The undersigned authorizes direct payment to this clinic in accordance with their regular rates and terms. All payments, including co-payment, co-insurance, deductibles, etc. are due at the time services are provided. Arrangements for payment of all accounts for services must be made before discharge. Kirsch Therapy may assess a $10.00 late fee, per month of non-payment, on any account from the 28th day after the account is due. In the event that the account for services rendered to the patient is referred to a collection agency or an attorney for collection, the undersigned shall pay a $50.00 collection fee and all reasonable collection costs, including attorney's fees and court costs, including costs on appeal.
4. _____The undersigned authorizes direct payment to Kirsch Therapy of any health benefits otherwise payable to or on behalf of the undersigned for his or her services provided through this clinic. Should direct payment of health benefits not cover all charges, if the services are not covered under your insurance, if the services have not been otherwise approved for payment by your insurance or should payment be denied by the insurance company or payer, it is understood by the undersigned that he/she is financially responsible for any remaining balance.
5. _____If home visits are being provided and the client is not available by 10 minutes after the scheduled meeting time and has not attempted to notify the office, the full treatment rate will be billed to the undersigned.
6. _____Please notify the office of any cancellations by 8:00 am on the day of your appointment. If you do not call to cancel you will be charged $25.00.

The undersigned certifies that he/she has read the entire document, and is the patient, the patient's legal representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____	_____	_____
DATE	PATIENT/GAURDIAN SIGNATURE	RELATIONSHIP

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