Burger Physical Therapy & Rehab

PO Box 1100
Folsom CA 95763-1100
Phone:

CONSENT FOR TREATMENT

I, the undersigned, hereby agree and give my consent to Burger Physical Therapy & Rehab to administer such treatment and care as is prescribed and considered therapeutically necessary on the basis of findings during the course of treatment. I also authorize Burger Physical Therapy & Rehab to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for the services rendered. The information provided is accurate to the best of my knowledge.

Relationship to Patient:

_____ _____

Signed By Date

Burger Physical Therapy & Rehab

PO Box 1100
Folsom CA 95763-1100

NOTICE OF PRIVACY PRACTICES

Effective 01/01/2020, Revised 01/01/2020

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and or refuse the release of specific information outside of our system except when the release is required or authorized by law or regulation.

Acknowledgement of Receipt of this Notice
You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment.

Who Will Follow this Notice
All physicians, licensed health care personnel, employees, staff and other office personnel. Any independent health care professional who may provide services at our office and is authorized to enter information into your medical record. All students or trainees. Any persons or companies with whom Burger Physical Therapy & Rehab contracts for services to help operate our practice and who have access to our patients' medical information.

Our Responsibility Regarding Protected Health Information
Your 'protected health information' is individually identifiable health information. This includes demographics such as age, address, email address, and relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to do the following:

Make sure that your protected health information is kept private.

Give you this notice of our legal duties and privacy practices related to the use and disclosures of your protected health information.

Follow the terms of the notice currently in effect.

Communicate any changes in the notice to you.

We reserve the right to change this notice. Its effective date is at the top of the first page and at the bottom of the last page. We reserve the right to make the revised or changed notice effective for health information we already have about your child as well as any information we receive in the future. You may obtain a Notice of Privacy Practices by calling the phone number at the top of this notice.

Our System
Burger Physical Therapy & Rehab works with several agencies and referral sources. Your health information will be shared in the following manner:

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes disclosure to your physician or other health care providers who becomes involved in your care.

Within our office for administrative activities, quality assessment, oversight and peer review.

With our billing personnel and as necessary to obtain payment for your health care services.

With your insurance company or other payers as required for payment.

With the referring agency and case manager.

With any other provider, school and/or agency with your written request. You may request written or verbal information sharing in writing. Your request should include a specified period of time for information sharing.

Required by Law

We may use or disclose your protected health information if law or regulation requires the use or disclosure. We will notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Health Oversight
We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Legal Proceedings
We may disclose protected health information during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Parental Access
We may disclose your protected information to parents, guardians and persons acting in similar legal status.

For Health Care Operations
Burger Physical Therapy & Rehab, staff and business associates may use and disclose medical information about you to operate this office. For example, Burger Physical Therapy & Rehab may use medical information to call out your name in the waiting room, to review treatment and services or to evaluate the qualifications and performance of therapists in caring for you. Burger Physical Therapy & Rehab, may also disclose information to licensing authorities or offices who evaluate qualifications and review care to determine if Burger Physical Therapy & Rehab and its therapists can be licensed, credentialed, certified or approved under a health plan or to treat patients at a particular facility. Burger Physical Therapy & Rehab, may contract with other professionals or companies, such as medical record transcription services, consultants, financial advisors or legal counsel, to help us run the practice and who have agreed to follow our Notice of Privacy Practices.

Contacting You
Unless Burger Physical Therapy & Rehab has agreed in writing to your written request to handle these matters differently, Burger Physical Therapy & Rehab may use and disclose medical information to leave you a message or send you a letter concerning an appointment or to ask you to call concerning your care or your account. Burger Physical Therapy & Rehab will use the contact information that you provide.

Individuals Involved in Your Care
Burger Physical Therapy & Rehab may disclose medical information about your child to a friend or family member who is involved in your medical care, unless you object. You can object to these disclosures by notifying Burger Physical Therapy & Rehab in writing that you do not wish any or all individuals involved in your care to receive this information. If you are not present or cannot agree or object, Burger Physical Therapy & Rehab will use our professional judgment to decide whether it is in your best interest to disclose relevant information to someone who is involved in your care.

Research
Under certain circumstances, Burger Physical Therapy & Rehab may use and disclose medical information about your child for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received treatment to those who received another for the same condition. Burger Physical Therapy & Rehab will obtain your written consent if the researchers will know who your child is. Medical information about your child that has had all identifying information removed may be used for research without your consent.

Uses and Disclosures of Protected Health Information Requiring Your Permission
In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. Since some of our therapies are provided in your home or other natural environments, those present during the session, including friends, family, or day care providers may hear health information regarding your child. Please notify our office in writing if you do not want your protected health information to be discussed with those present during the session. If your child receives therapy at our office the therapist may discretely share your progress in the waiting room in front of other patients. If you do not wish to have your progress shared in the waiting room, please notify our office in writing.

Your Rights Regarding Your Health Information
You may exercise the following rights by submitting a written request to the Burger Physical Therapy & Rehab office.

You may inspect and obtain a copy of your protected health information that we keep as a part of medical and billing records.

You may ask us not to use or disclose any part of your health information for treatment, payment, or health care operations.

Your request must be made in writing. This request will be honored if we mutually agree that the restriction will not harm your child.

You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request.

We will accommodate reasonable requests, when possible.

If you believe that the information we have about your child is incorrect or incomplete, you may request an amendment to your protected health information as long as we are responsible for and maintain this information.

Federal Privacy Laws
This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). There are several other privacy laws that also apply including the Freedom of Information Act and the Privacy Act. These laws have been taken into consideration in developing our policies and this notice of how we will use and disclose your protected information.

Changes to the Notice of Privacy Practices
Burger Physical Therapy & Rehab reserves the right to change this notice. Burger Physical Therapy & Rehab reserves the right to make the revised or changed notice effective for medical information already held about you as well as any information received in the future. Burger Physical Therapy & Rehab will post a copy of the current notice in the office. The notice will remain in effect for each subsequent visit unless changed. If the notice changes, a copy will be available to you upon request.

Questions and Complaints
If you have any questions about this notice, please contact the Privacy Officer at . To notify our office in writing of a request please mail to the following: Privacy Officer, Burger Physical Therapy & Rehab. PO Box 1100, Folsom CA, 95763-1100. If you have a complaint about your privacy rights, you may file a written complaint with this office or with the Secretary of the United States Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer at . You will not be penalized for filing a complaint.

PAYMENT FOR SERVICES AGREEMENT
Services to be Provided

Burger Physical Therapy & Rehab will provide therapy services for your child (patient) in accordance with the orders provided by the patients physician. It is understood that licensed therapists employed by Burger Physical Therapy & Rehab will complete the services provided. The responsibly party gives permission for the patient to receive therapy services provided by Burger Physical Therapy & Rehab.

Insurance Benefits

Burger Physical Therapy & Rehab will verify the patients benefits, file the claims for services provided with the insurance carrier, and notify the responsible party of their financial responsibility. The responsible party understands that the verification of benefits and authorization is not a guarantee of payment and that they are responsible for all charges not paid by the insurance company.

Assignment of Insurance Benefits

The responsible party authorizes any insurance carrier that provides insurance coverage for the patient, to make direct payments to Burger Physical Therapy & Rehab for all services rendered. The responsible party will accurately inform Burger Physical Therapy & Rehab of the patients insurance coverage and provide information regarding coverage changes within 5 working days of the change.

Release of Information for Reimbursement

The responsible party authorizes the release of information pertaining to the patients diagnosis and course of treatment to Burger Physical Therapy & Rehab by the patients physician and any other therapy service providers involved in the patients care. The responsibly party also authorizes the release of information to the patients physician and any other agencies related to reimbursement issues.

_____ _____

Signed By Date

Burger Physical Therapy & Rehab
PO Box 1100
Folsom CA 95763-1100
Phone:

Notice of Privacy Practices Acknowledgement

My signature below confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Information Portability and Accountability Act of 1996 (HIPAA). I acknowledge that I have been provided with Burger Physical Therapy & Rehab Notice of Privacy Practices that describes how my health information is used and shared. I understand that Burger Physical Therapy & Rehab reserves the right to change this notice at any time. I may obtain a current copy by contacting the clinic or the billing office.

Our organization may contact you to remind you of any appointments, health care treatment options, billing concerns, or other health services that may be of interest to you.

May we contact you at home?
Home Phone:
OK to leave a message?

May we contact you at work?
Work Phone:
OK to leave a message?

May we contact on your cell?
Cell Phone:
OK to leave a message?

This authorization will remain in effect until revoked in writing. Copies of your chart or any other written information are not covered by this authorization.

_____ _____
Signed By Date

Raintree Systems
27307 Via Industria
Temecula, CA 92590
Phone: (951) 252-9400 Fax: (951) 252-9401

PLEASE NOTE: THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.

Patient Name: Date of Birth:

Please check the PHI to be restricted:

[ ] Visit Notes [ ] Patient History

[ ] Hospital Notes [ ] Prescription Information

[ ] Cell Phone [ ] Home Phone

[ ] Work Phone [ ] Appointment Reminders

CONSENT TO RELEASE INFORMATION

Please list the people and their relationship who you give consent to release information (spouse, children, etc.).

Name of Patient Representative: Relationship:

Name of Patient Representative: Relationship:

Name of Patient Representative: Relationship:

_____ _____

Signed By Date

BE INFORMED

Know Your Insurance Benefits

You are responsible for charges incurred during the course of treatment. As a courtesy, we will contact your insurance company in order to verify your benefits and your applicable copayment, deductible and/or coinsurance amounts. This is an estimate provided by your insurance carrier to us. It is only upon claim submittal and processing (which can take up to 90 days or more) that we are informed by your insurance company of the actual portion you owe of your treatment cost. It is ultimately your responsibility to inform yourself of your insurance benefits, limitations and financial responsibilities. We assume no liability for inaccurate benefit quotations made by your insurance carrier in our verification process. Please contact your insurance company if you have questions regarding your coverage. You may also contact our billing office if you determine any discrepancies or have any questions: call (916) 351-1083 or email Billing@BurgerRehab.com.

Thank You,

Burger Physical Therapy

By signing this agreement, I understand and agree to the conditions stated above

_____ _____

Signed By Date

Burger Physical Therapy & Rehab
PO Box 1100
Folsom CA 95763-1100
Phone:

AUTHORIZATION TO RELEASE PAYMENT & PATIENT INFORMATION

We protect your medical information as described under HIPAA guidelines and outlined in the attached notice of privacy practices for health information.

Within a clinic setting some patients may receive their treatment within a large area (e.g. gym, pool, and hand therapy room), therefore, another patient may be able to hear information about a patient's diagnosis or progress in therapy. You will always be able to speak privately with the therapist. If you prefer to be treated in a separate area, we will be happy to arrange that for you. Please make your request known prior to your treatment.

I certify that the information given by me is correct. I authorize release of all records necessary for treatment and payment. I request that payment of authorized benefits be made in my behalf, directly to Burger Physical Therapy & Rehabilitation Agency, Inc. I consent to, and authorize the Rehabilitation Agency to administer all treatments and services that may be considered advisable in the judgment of my physician in accordance with agency policies.

CANCELLATION & NO-SHOW POLICY

Please arrange your appointments with the receptionist. The receptionist will provide you with an appointment card for your convenience. Your appointment is **reserved** for you. **Any cancellations should be called into our office at least 24 hours in advance or you may be charged $50.00 for the appointment. No-shows will be charged $50.00 for the appointment. You will be required to pay the $50.00 for your missed appointment on your next visit. If an interpreter is arranged for you by us for your appointment and you do not give the required 24 hours notice of a cancellation or you no-show for your appointment, you will be required to pay $150.00 for your missed appointment prior to scheduling your next visit. Your insurance will not pay this. It is your responsibility**. Telephone lines are open 24 hours with a recorder. Consecutive "no shows" can cause you to lose your time slot for follow-up appointments. If the occurrence involves a Workers' Compensation case, the carrier will be notified of failure to attend therapy

PAYMENT AGREEMENT

We will bill your primary insurance carrier; however, all bills are due and payable within 30 days. Patients are financially responsible for all charges incurred during treatment, regardless of expected reimbursement by insurance. By signing this, I understand and agree that if my insurance carrier or other party makes payments to me or to my representative for my treatment, I agree to immediately remit those funds to Burger Physical Therapy and Rehabilitation Agency, Inc.

By signing this, I understand and agree that if my account becomes past due, I will be charged a pre-collect processing fee of $35. I also understand and agree that if my account is turned over to a collection agency or an attorney for collections, I am responsible for all costs of collecting monies owed including, but not limited to, collection agency fees, court costs and attorney fees.

CO-PAYMENT POLICY: Co-payments are a fixed fee determined by your insurance plan and must be paid at the time of service. If you have a copayment and Medi-Cal is your secondary insurance, you will be required to pay your copay at the time of service as we are not a Medi-Cal contracted provider.

PAYMENTS BY CHECK: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you will not receive your check back from your financial institution.

WORKERS' COMPENSATION POLICY: We will accept most Workers' Compensation cases. It is to be understood by

the patient if, for any reason, the case is denied by the Workers' Compensation carrier, the patient will be totally responsible for the bill and the account must be paid off within 60 days of the date it was denied.

CHANGES IN INSURANCE: We have agreed to bill your insurance for the services provided in the course of your care. Due to increasingly specific benefits and requirements conditional for reimbursement, it is imperative that you notify the office immediately when your coverage changes. Failure to do so could result in you being responsible for the bill

_____ _____

Signed By Date

Medical History

Patient Name: _____

Pregnancy / Delivery

Pregnancy Proceeded ☐ Without Complications
☐ With Complications

- ☐ Eclampsia
- ☐ Gestational Diabetes
- ☐ Multiple Births
- ☐ Polyhydramnios
- ☐ Positive for Cytomegalovirus 'CMV'
- ☐ Positive for Herpes
- ☐ Positive for HIV
- ☐ Positive for Strep B
- ☐ Pre-eclampsia
- ☐ Premature Labor
- ☐ Substance Exposure
- ☐ Toxemia
- ☐ Other _____

Length of Pregnancy (in weeks)_____ Prenatal care was ☐ Received ☐ Not Received

Delivery Proceeded ☐ Without Complications
☐ With Complications

- ☐ Abruptio Placenta
- ☐ Breech Presentation
- ☐ Low Birth Weight
- ☐ Negative Vacuum
- ☐ Non-progressive/unproductive Labor
- ☐ Occiput Posterior Postion (Face up)
- ☐ Placenta Previa
- ☐ Premature Rupture of Membranes
- ☐ Transverse Presentation
- ☐ Prolapsed Cord
- ☐ Use of Forceps
- ☐ Uterine Rupture
- ☐ Umbilical Cord Wrapped Around Neck
- ☐ Other _____

Delivery was ☐ Vaginal ☐ C-section ☐ Emergency C-section Length of child's hospital stay: _____

Mother's age at time of birth _____ Birth Hospital _____

Needed to be transferred to another hospital ☐ Yes ☐ No

Transfer Hospital _____

Birth Weight _____ Birth Height _____ Apgar 1 min_____ 5 min _____ 10 min _____

Additional Comments _____

_____

_____

Multiple child pregnancies: # of live births: _____ # of still births: _____

Additional details of birth _____

_____

_____

Complications Following Birth

- ☐ Anemia of Prematurity
- ☐ Bronchopulmonary Dysplasia 'BPD'
- ☐ Cleft Lip
- ☐ Cleft Palate
- ☐ Club Foot
- ☐ Cytomegalovirus
- ☐ ECMO
- ☐ Failure to Thrive
- ☐ Hyperbilirubinemia
- ☐ Intrauterine Growth Retardation 'IUGR'
- ☐ IVH Bleed Grade I
- ☐ IVH Bleed Grade II
- ☐ IVH Bleed Grade III
- ☐ IVH Bleed Grade IV
- ☐ Jaundice treated by light therapy &/or blanket
- ☐ Meconium Aspiration
- ☐ Necrotizing Enterocolitis 'NEC'
- ☐ Neonatal hypoxia
- ☐ Oxygen dependency
- ☐ PDA
- ☐ Positive dependency
- ☐ Respiratory Distress Syndrome
- ☐ Respiratory Stridor
- ☐ Respiratory Syncytial Virus 'RSV'
- ☐ Retinopathy of Prematurity 'ROP'
- ☐ Thrombocytopenia (Low Platelet count)
- ☐ Ventilator Dependency
- ☐ VP Shunt
- ☐ Other _____

Diagnosed or Suspected Syndromes

_____

_____

Current Medications

_____

_____

_____

_____

Allergies

_____

_____

_____

Current Vitamins, Herbs, Minerals, Homeopathics

_____

_____

Hearing Test

- ☐ Never Tested, No Concerns
- ☐ Never Tested, Have Concerns
- ☐ Normal Test Results
- ☐ Abnormal Test Results

Last Test Date _____

Results

_____

_____

_____

Concerns

_____

_____

_____

Vision Test

- ☐ Never Tested, No Concerns
- ☐ Never Tested, Have Concerns
- ☐ Normal Test Results
- ☐ Abnormal Test Results

Last Test Date _____

Results

_____

_____

_____

Concerns

_____

_____

_____

Current Physicians			
Name	**Specialty**	**Reason**	**Date of last visit**

Diagnostic Tests		
Test	**When**	**Details/Results**
Auditory Brainstem Response		
Biopsy		
Blood Work / Lab Tests		
Bone Density Scan		
CT Scan		
EEG		
EMG		
Lower GI		
Motility Study / Empty Scan		
MRI		
NCV		
Swallow Study		
Ultrasound		
Upper Endoscopy		
X-Ray		

Surgeries and Procedures		
Type	**Date**	**Results/Details**

Does the child have:

- ☐ Allergies
- ☐ Arteriovenous malformation (AVM)
- ☐ Anoxic brain injury
- ☐ Asthma/respiratory breathing problems
- ☐ Autism
- ☐ Baclofen Pump
- ☐ Cerebral Palsy (CP)
- ☐ Cerebral Vascular Accident (CVA)
- ☐ Chronic Ear Infections
- ☐ Colic
- ☐ Constipation
- ☐ Diarrhea
- ☐ Down Syndrome
- ☐ Hip subluxation
- ☐ Hydrocele
- ☐ Laryngomalacia
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Periventricular Leukomalacia
- ☐ Reflux
- ☐ Scoliosis Degrees? _____
- ☐ Seizure Condition
- ☐ Sleep disorder
- ☐ Sleep problems
- ☐ Shunts
- ☐ Torticollis
- ☐ Traumatic brain injury (TBI)
- ☐ Tube Feeding
- ☐ Tubes in ears
- ☐ Vagal Nerve Stimulator
- ☐ None

Other Medical Conditions

_____

_____

_____

Orthopedic Conditions

_____

_____

_____

Additional Comments

_____

_____

_____

Developmental History

Is the child able to:	Began at age (in months):
Bringing both hands to mouth	
Buttoning pants/shirt	
Come to sitting from a lying position	
Creeping or crawling alone	
Fully Toilet trained	
Grabbing a toy	
Holding head up alone	
Pulling self to standing position	
Rolling Over	
Self-bathing	
Self dressing	
Sitting alone without support	
Standing unsupported	
Tying shoes	
Walking with support	
Walking unaided	
Zipping/unzipping jacket	

Is your child ☐ Right Handed ☐ Left Handed ☐ Neither

Concerns about handwriting? ☐ Yes ☐ No Describe: _____

How does child get around the house? _____

Favorite Toys / Play Activities _____

Description of Child

☐ Active ☐ Affectionate ☐ Aggressive ☐ Calm ☐ Cautious ☐ Curious ☐ Demanding ☐ Difficult to Comfort ☐ Distractible ☐ Fearful ☐ Fearless ☐ Fussy ☐ Insecure ☐ Motivated ☐ Passive ☐ Persistent ☐ Playful ☐ Shy ☐ Stubborn ☐ Withdrawn ☐ Other: _____

Sensory processing & Regulation (please select all that apply)

☐ Avoids getting messy
☐ Seeks out (craves) touch or movement
☐ Stumbles or falls frequently
☐ Appears awkward or less coordinated
☐ Flaps hands
☐ Allows brushing of teeth
☐ Bangs on surface, bangs/hits head
☐ Fatigues quickly
☐ Has self-abusive behaviors
☐ Resists certain tasks or environment
☐ Spins things or self
☐ Is sensitive to lights,sounds or noise
☐ Sleeps a lot
☐ Resists touch
☐ Walks on toes
☐ Lines up toys or objects
☐ Seeks out (craves) visually stimulating objects
☐ Seeks out (craves) stimulating sounds
☐ Resists certain movements (e.g. bouncing, swinging, upside down)
☐ Has difficulty figuring out how to move body or takes more time with movements
☐ Does not tolerate certain textures (e.g. clothing,surfaces,foods)
☐ Uses lots of pressure when touching someone or holding object
☐ Has difficulty transitioning from one activity to another
☐ Has difficulty falling asleep
☐ Has difficulty remaining asleep through the night
☐ Appears Lethargic/sleepy all the time
☐ Has poor sense of body in space, runs into things
☐ Seeks support for posture (e.g. leans on furniture, walls or people, holds head)
☐ Demonstrates stiff or rigid movement patterns
☐ Hyperfocussed (on specific tasks, people, objects, etc.)

Other: please describe _____

Social/Emotional Skills

- ☐ Is easily distracted
- ☐ Calms self easily
- ☐ Gets angry/frustrated easily
- ☐ Is aggressive towards others
- ☐ Prone to emotional outbursts
- ☐ Doesn't allow others to join in play
- ☐ Has difficulty making friends
- ☐ Plays with peers
- ☐ Other: please describe _____
- ☐ Only plays with adults
- ☐ Prefers to play alone
- ☐ Has difficulty with separations
- ☐ Has poor eye contact

Feeding

Describe Any Feeding Problems

_____

Food Likes

_____

_____

Food Dislikes

_____

_____

Feeding Milestones			
When did the child begin?	**Age (in months)**	**Milestone**	**Age (in months)**
Using a Bottle		Using a Straw	
Using a Pacifier		Stop Using a Bottle	
Eating baby food		Stop Using a Pacifier	
Eating junior food		Using Utensils to Eat	
Eating table food		Holding own bottle/cup	
Drinking from a Cup		Self-feeding	
Drinking from a Sippy Cup			

Breast Feeding

- ☐ # times currently breast fed per day _____
- ☐ Weaned from breast feeding at age: _____
- ☐ Was never breast fed

Current Feeding Adaptations

- ☐ Thickened Liquids: Consistency: _____
- ☐ Adapted Utensils Details: _____
- ☐ Adapted seating Details: _____
- ☐ Calorie supplements Details: _____
- ☐ Tube Feeding Amount: _____ Times per day: _____ ☐ Continuous ☐ Bolus

Areas of Difficulty

- ☐ Chewing
- ☐ Drooling
- ☐ Transitioning Between Foods
- ☐ Jaw shifts/slides/juts
- ☐ Communication Needs
- ☐ Swallowing
- ☐ Understanding Words

Speech Language

Communication Skills		
Does the child:	Yes	No
Have speech that is understood by most people?		
Respond correctly to yes/no questions?		
Follow simple instructions?		
Respond when name is called?		
Stutter?		
Recognize objects, people, and places?		

Speech Milestones			
When did the child begin?	**Age (in months)**	**Milestone**	**Age (in months)**
Babbling		Putting 2 words together	
Saying first words		Using short sentences	
Naming familiar objects			

First Words _____

Augmentative Communication Device _____

Primary Communication ☐ Verbal ☐ Non-Verbal ☐ None

Methods of communication used:

☐ Vocalizations ☐ 2 word Phrases ☐ Facial Expressions ☐ Manual Sign Language ☐ Pointing
☐ Single Words ☐ Complete Sentences ☐ Body Language ☐ Gestures ☐ Eye Gaze

Please describe current speech concerns: _____

_____

_____

_____

Home Environment

Child lives with: (Please select all that apply)

☐ Birth mother ☐ Step-mother ☐ Siblings
☐ Birth father ☐ Step-father Please list siblings ages: _____
☐ Adoptive mother ☐ Grandmother ☐ other relative
☐ Adoptive father ☐ Grandfather Please specify: _____
☐ Legal guardian
Please specify: _____

Additional Comments: _____

_____

_____

Adoption

Age at adoption: _____

Additional Details: _____

Type of Home

☐ Single Level ☐ Assisted Living Facility
☐ 2 Level ☐ Skilled Nursing Facility
☐ Ground Floor Apartment ☐ Group Home
☐ Upper Level Apartment ☐ Other _____

Accessibility

Stairs to get into home: _____ Handrail? ☐ Right ☐ Left ☐ None
Ramp to get into home? ☐ Yes ☐ No
Stairs in home: _____ Handrail? ☐ Right ☐ Left ☐ None

☐ Bathroom on Main Level ☐ Bedroom on Main Level
☐ Bathroom on Upper Level ☐ Bedroom on Upper Level

Additional Comments: _____

_____

_____

Equipment presently used (Please select all that apply)

Equipment	Approx. Age	Details	Uses at Home	Uses at School/Day Care
Braces				
Walker				
Stander				
Manual Wheelchair				
Power Wheelchair				
Hoyer Lift				
Weighted Vest				
Hand Splint(s)				
Track System				
Other:				

Describe any home program that is currently performed (e.g. stretching, strengthening, brushing, etc)

_____

_____

_____

Describe any community groups or sports activities the child is involved in

_____

_____

Grade in School _____ Name of School _____

Does your child have an IFSP? ☐ Yes ☐ No

Does your child have an IEP from school? ☐ Yes ☐ No

Has your child had a psychological or neuropsychological evaluation completed? ☐ Yes ☐ No

Therapy Services	Type	Status	How often?	Where?
Assistive Technology				
Audiology				
Behavior Therapy				
Developmental History				
EI Services				
Intensive Suit Therapy				
Vision Therapy				
Nutrition				
Occupational Therapy				
Physical Therapy				
Social Therapy				
Speech / Language Therapy				
Developmental Follow-up Clinic				
Other:				

Additional Comments: _____

_____

_____