CASE HISTORY QUESTIONNAIRE

Child's Name________________________________ Today's Date______________________
Date of Birth_______/______/_______ Age:_____________________________

What are your primary concerns for having your child evaluated and treated?

____
____
____

Child lives with: ☐ birth parents ☐ foster parents ☐ adoptive parents ☐ parent & step parent
☐ one parent ☐ grandparents ☐other

Is there a language other than English spoken in your home? ☐ YES ☐ NO

If yes, which one?_____________________________________

Does the child speak the language? ☐YES ☐ NO

Does the child understand the language? ☐YES ☐ NO

Who speaks the language?____

Which language does the child prefer to speak at home? __________________

Is your child currently taking any medications? ☐ YES ☐ NO
If Yes please list :

Name of Medication	Dosage	Times given	Used for

United Way
United Way of Central Alabama, Inc.

PREGNANCY & BIRTH HISTORY

Did mother have any illnesses or complications during pregnancy or delivery? □ Yes □ No
If yes please explain____

____

Any medications, alcohol, or other drug use during pregnancy? □ Yes □ No
If yes please explain____

____

At how many weeks was your child born__________________ Birth Weight__________________
Born by Vaginal or C-section?__________________________

Did your child require hospital stay or time in NICU? □ Yes □ No
If yes please explain____

____

Did your child require any medical procedures before, during or after birth? □ Yes □ No
If yes please explain____

____

MEDICAL HISTORY

Please describe illnesses, medical issues, surgeries, or hospitalizations that your child has had and when.

____

____

Please answer the following about your child:

Immunizations up to date?	□ Yes	□ No	If no, explain____________________
Seizures	□ Yes	□ No	If yes, explain____________________
Seizures with fever	□ Yes	□ No	If yes, explain____________________
Growth problems	□ Yes	□ No	If yes, explain____________________
Sleep problems	□ Yes	□ No	If yes, explain____________________
Dental problems	□ Yes	□ No	If yes, explain____________________
Feeding Tube	□ Yes	□ No	If yes, explain____________________
Gastroesophageal Reflux	□Yes	□ No	If yes, explain____________________
Feeding problems	□Yes	□ No	If yes, explain____________________
PE Tubes	□ Yes	□ No	If yes, explain____________________
Cleft Palate/Lip	□ Yes	□ No	If yes, explain____________________

Current Weight ____________

Current feeding method (check all that apply): □ Bottle fed □ Breast fed □Baby food □ Table Food □ Tube Fed □ Special Diet__________________

Do you have any concerns about what or how your child eats? □ Yes □No
Is your child a picky eater? □ Yes □ No
Does your child have any food allergies? □ Yes □ No
Do you have concerns about your child's weight? □ Yes □ No

Have you, any family members, teachers or physicians ever questioned whether your child has:

- □ Language Delay
- □ Hyperactivity/ADD/ADHD
- □ Hearing Problems
- □ Vision Problems
- □ Autism Spectrum Disorders
- □ Physical Disability/Cerebral Palsy
- □ Intellectual Delay
- □ Developmental Delays
- □ Learning Disability

Are there any other precautions we should know about that are not already described?_______________

FAMILY HISTORY

Is there any known history of the following in the immediate or extended family?

□Autism/PDD □ ADHD □ Learning Disabilities
□ Hearing Loss □ Stuttering □Speech/Language Delays

HEARING & VISION

Has your child's hearing been recently evaluated? □ Yes □ No
If yes, when, by whom and what were the results____

____

Is vision within normal limits? □ Yes □ No

____

DEVELOPMENTAL MILESTONES

Please note when each of the following occurred.

Roll over_________________ Sit Up____________
Crawl___________________ Was crawling phase brief? □ Yes □ No
Walk____________________ Drink from a cup__________________
Feed Self_________________ Toiled Trained_____________________

SPEECH & LANGUAGE DEVELOPMENT

Please describe how your child expresses their wants and needs (pointing, pulling caregiver, signing, single words, short phrases, sentences, augmentative communication, picture exchange)?____________

____

If your child is talking, please indicate at what age your child began to:
Babble_________ First Words______________ 2-3 word phrases_______________

How much of your child's speech do you understand?
□ 25% or less □ 25-50% □ 50-75% □ 75-100%

How much of your child's speech do others understand?

□ 25% or less □ 25-50% □50-75% □75-100%

Are there specific sounds your child has difficulty saying?________________________________

Does your child demonstrate frustration when he/she is not understood? □ Yes □ No
If yes please explain____

SELF HELP
Please describe how much assistance does your child need for:

Eating ____
Dressing____
Toileting____
Bathing____
Washing hands &face__________________________________
Brushing teeth &hair__________________________________

BEHAVIOR & SOCIAL SKILLS

Follows verbal directions	Yes	No	Comment:
Initiates conversations	Yes	No	Comment:
Makes eye contact when Speaking	Yes	No	Comment:
Has safety awareness	Yes	No	Comment:
Is impulsive or a risk taker	Yes	No	Comment:
Displays aggression towards self or others	Yes	No	Comment:
Enjoys roughhouse play	Yes	No	Comment:

Please describe your child's personality.___________________________________
____
____

What do you feel are your child's strengths?_________________________________
____
____

Does your child have tantrums? □ Yes □ No If yes, how often?_______________________

How do you handle discipline issues at home?_________________________________
____
____

What is used for motivation or as an incentive for positive behavior at home or at school?________________

____

____

Does your child tend to play alone or with others?________________________________

SENSORY PROCESSING

Does your child seem over or under sensitive to sensory input?

Sounds____

Touch____

Movement____

Light____

Pain____

Temperature____

Clothing____

How well does your child handle transitions/changes in routine?____________________

____

What are your child's favorite toys/activities?______________________________

____

EDUCATION

Name of School/Daycare______________________________ Grade:______________

Teacher___________________________ Weekly schedule____________________

Type of classes ◻Regular ◻Special Education ◻Life Skills ◻Other

Do you have any academic concerns?____

If your child is not in school/daycare, where do they stay during the day?_______________

What are your goals/what do you or your child hope to gain from therapy?_______________

____

Please complete any of the following pertaining to your child. It is important that you complete as much as possible.

Birth, Treatment and School History Services Form

Type of Service Provider	Agency/Provider Name	What was your child seen for	Most recent dates seen
Hospitalizations			
Hospitalizations			
Pediatrician			
Neurologist			
Orthopedist			
Geneticist			
Eye Specialist			
Hearing Specialist			
Otorhinolaryngologist ENT			
Psychiatrist			
Psychologist			
Nutritionist/Dietician			
Occupational Therapist			
Physical Therapist			
Speech Therapist			

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM

PATIENT REGISTRATION FORM

PATIENT INFORMTION					
PATIENT LAST NAME	FIRST NAME	MI	GENDER M F	RACE	D.O.B

PARENT/GUARDIAN'S INFORMATION					
PARENT/GUARDIAN LAST NAME	FIRST NAME	MI	RELATIONSHIP TO PATIENT		
STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY	
HOME PHONE#	CELL PHONE #	WORK PHONE #	GENDER M F	MARITAL STATUS S M W D SEP	D.O.B.
EMPLOYER	OCCUPATION				

Additional person's authorized to bring my child to Easterseals for therapy and can consult with the therapist	
NAME	RELATIONSHIP TO CHILD
NAME	RELATIONSHIP TO CHILD
NAME	RELATIONSHIP TO CHILD

IN CASE OF AN EMERGENCY NOTIFY		
NAME	PHONE #	RELATIONSHIP TO CHILD

INSURANCE INFORMATION					
PRIMARY INSURANCE COMPANY			SECONDARY INSURANC COMPANY		
NAME OF INSURED			NAME OF INSURED		
GROUP #	POLICY #	EFFECTIVE DATE	GROUP #	POLICY #	EFFECTIVE DATE

GENERAL INFORMATION	
EMAIL ADDRESS:	
HOW DID YOU HEAR ABOUT EASTERSEALS:	
REFERRING DOCTOR:	PHONE:

Appointment Policy for Clients Seen at the office

It is our intention to provide your child with the best possible therapy services. For this reason, we ask you to take a few moments to review policies that affect the way services are provided.
Please initial in each box.

□ **Tardiness**

Therapy sessions are set at 30 minute intervals unless otherwise specified by the therapist.
If you are **15 minutes late your child cannot be seen**. We will do our best to reschedule that appointment within the same day or within the same week. **If the appointment is not rescheduled it will be considered a "NO SHOW".**

□ **Cancellations**

If your child must be absent from a therapy session, please reschedule your appointment **within 30 days**. If you choose not to reschedule your appointment; after two cancellations your child will lose their time slot and will have to be scheduled on a week to week basis with the receptionist, and your therapist may be different.
If cancellations continue after the time slot has been removed, you will be discharged.

□ **No-Show Policy**

After two (2) No Shows, your child will be discharged, unless you reschedule the missed appointment within the same week. Your child may return to therapy after six months.

□ **Illness Policy**

If your child has had fever, vomiting or diarrhea within 24 hours of your scheduled appointment, please contact our office and cancel his/her appointment. If your child cannot attend school due to illness, he/she should not attend therapy. It is also requested that sick siblings not attend therapy. You can always reschedule the appointment

□ **Vaccination Policy**

To ensure the health and safety of all our patients, their families, and staff, patients seen in the clinic must be up to date on their vaccinations. If a parent/guardian/caregiver elects not to have their child(ren) vaccinated, they will be asked to find another clinic that shares their views.

Therapy Policies for Clients Seen offsite Locations

□ If your child is absent from school, will have a field trip, etc. on the day of therapy; please notify our office at 205-314-2165. Except in cases of sickness or emergencies, we request a 24 hour notice. If the therapist drives to the school and your child is not present, you will be charged a no show fee of $35.00.

□ If your child is SICK or in the event of an emergency, please contact the office before school starts. You can leave a message on our office voicemail or leave a message with the receptionist to avoid the **no show fee of $35.00**.

□ We require a credit card to be kept on file in our office. Any time your card is charged, you will receive an e-mail notifying you of the charge. If you would prefer not to have your credit card charged, you may keep an "account" for your child. Just send a check to our office for the number of visits you would like to pay in **advance.** As long as there is money in your child's account, your credit card will not be charged.

□ In order to best meet your child's needs in the school setting, we would like your permission to discuss your child with school personnel.

I understand and agree to the above policies and a copy has been given to me for my records.

______________________________ ______________
PARENT/GUARDIAN SIGNATURE DATE

EASTERSEALS PEDIATRIC THERAPY SOUTH • 240 COMMERCE PARKWAY • PELHAM, AL 35124
P • 205.314.2165 F • 205.783.1128 • eastersealsbham.org

PATIENT

DISCLOSURE AND CONSENT FORM

Patient Name:____ **Date of Birth:**____________
First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and request that all insurance benefits be paid to Easterseals of the Birmingham Area for services provided to the above name patient.

CONSENT FOR MEDICAL CARE: I hereby give my permission and consent to Easterseals of the Birmingham Area for therapy and other services that may be prescribed or deemed advisable for rehabilitation treatment by a physician.

AUTHORIZATION TO RELEASE NON-PUBLIC INFORMATION: I certify that I have received and read a copy of the Easterseals of the Birmingham Area Notice of Privacy Practices and patient rights. I hereby authorize Easterseals of the Birmingham Area to release any of my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, or the processing of insurance benefits. (a complete copy is provided by request or is hanging in loby)

AUTHORIZATION TO MAIL, CALL, VOICEMAIL, EMAIL OR TEXT: I certify that I understand the privacy risks of mail, phone calls, email and text messages. I hereby authorize Easterseals of the Birmingham Areas representative to mail, call, email or text me with communication regarding my child's treatment, appointment times and referral recommendations. I understand that I have the right to rescind this authorization at any time by notifying Easterseals of the Birmingham Area to the effect in writing.

CONSENT TO TREATMENT: I hereby consent to evaluation, testing, and treatment as directed by my Easterseals of the Birmingham Area's therapist or his/her designee.

CONFIDENTIALITY: I understand that Easterseals of the Birmingham Area will not disclose or release information created or received about the above patient except for the purpose of:

a. Appropriate Medical treatment and/or development/assessment
b. Release to insurance companies for the purpose of payment
c. Other health care operations such as review of staff monitoring and/or evaluation and for purposes of Quality Assurance monitoring. For certain instances, I understand that I must sign an authorization permitting the disclosure or release of information.

PARENT SIGNATURE:______________________________________**DATE:**______________

GUARDIAN SIGNATURE:____________________________________**DATE:**______________
(if different from parent)

PARENT/GUARDIAN PRINTED NAME:____

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PHONE • 205•314•2165 FAX • 205•783•1128

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name:________________________________ Date of Birth:__________________
Medical Record Number or SSN: ___________________________________

I hereby authorize disclosure of protected health information as follows person/Organization Sending the Information:

____

____

Person/Organization Receiving the Information:

____

____

For the purpose of: ____
Specific Dates of Service: from____________ to ______________or □ All available records

The type and amount of information to be used or disclosed:

❑ Developmental Testing/Report	❑ Social/Developmental History
❑ Health/Medical Records	❑ Speech/Language Testing/Reports
❑ Progress Reports	❑ Staffing Reports, IFSP's
❑ Psychological Testing/Record	❑ Therapy/Testing Reports
❑ Screening/Intake Information	❑ Vision/Hearing Reports
❑ __________________________	❑ __________________________

I understand that:

1. This information is protected under federal law.
2. I may refuse to sign this authorization.
3. I have the right to revoke this authorization in writing, but if I do, it will not have any effect to the extent that Easter Seals Pediatric Therapy has taken action in reliance on it.
4. This Authorization will expire ______________________________(date or event). If I fail to specify an expiration date or event this authorization will expire in five years.
5. The above information will not be released to any other individual or agency except to the one listed above without prior written permission by the parent or legal guardian.
6. By signing below, I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law.
7. Treatment or payment will not be based on my signing this authorization.
8. Photocopies of this release form will be considered as an original.

____ ________________
Signature of Parent/Legal Guardian Date
If signed by legal guardian, please list agency and contact telephone number:_______________________

____
Witness

PHOTOGRAPHY AND/OR BIOGRAPHY RELEASE

I HEREBY GIVE Easterseals of the Birmingham Area the absolute and irrevocable right and permission, with respect to the photographs, story of me or intellectual property developed while in the Easterseals of the Birmingham Area's program:

- **To use, re-use, publish and re-publish the same in whole or in part, individually or in conjunction with other photographs, in any medium (included but not limited to newsletters, nominations, community awareness, social media and as of yet unheard-of media) and for any purposes whatsoever, including (but not by way of limitation) illustration, promotion, and advertising and trade, for a period of five years.**

I hereby release and discharge Easterseals of the Birmingham Area, from any and all claims and demands arising out of or in connection with the use of the photographs, story or intellectual property developed while in the Easterseals of the Birmingham Area's program including any claims from libel.

I have read and explained the forgoing and fully understand the contents thereof.

☐ **I have received a copy of this release for my personal records.**

X________________________________ X________________________________
Consumer/Patient Signature **Date**

X________________________________ X________________________________
If minor, parent/guardian **Date**

Address: ____

____

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HOW THERAPY WORKS AT EASTER SEALS

Just attending speech, occupational, and/or physical therapy each week is not enough! We all must work together as a team to help your child be successful and independent.

Here are some guidelines:

1. Good Attendance is vital for success. Try to come to therapy consistently or make up the sessions if have missed several in row.
2. Skills learned at therapy must be practiced and used at home and school. Do your homework!
3. Stay engaged, observe session in the observations rooms and encourage all family members to take an active role in improving your child's skills. Ask Questions!!

You child will be placed on a therapy break or discharged from this facility:

1. At your request.
2. After 2 no-shows to scheduled therapy appointments.
3. When goals have been mastered.
4. When test scores indicate age-appropriate skills.
5. If progress is no longer being made.
6. If attendance and/or family support is poor.
7. If behavior negatively impacts progress in therapy.

____________________________________ ________________

Parent/Guardian Signature Date

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