BELL PHYSICAL THERAPY PEDIATRICS INTAKE FORM

CHILD'S NAME | DATE OF BIRTH | TODAY'S DATE

ADDRESS

PARENT 1 NAME | EMAIL ADDRESS | MOBILE NUMBER

OCCUPATION | WORK PHONE

PARENT 2 NAME | EMAIL ADDRESS | MOBILE NUMBER

OCCUPATION | WORK PHONE

NAMES AND AGES OF THOSE IN HOME

PRIMARY LANGUAGE SPOKE IN HOME

PEDIATRICIAN | PEDIATRICIAN PHONE NUMBER

REFERRED BY

IN YOUR OWN WORDS, WHAT BRINGS YOU TO BELL PHYSICAL THERAPY?

WHEN DID YOU FIRST NOTICE THESE CONCERNS? WHY ARE YOU SEEKING PHYSICAL THERAPY SERVICES AT THIS TIME?

HAS YOUR CHILD RECEIVED PREVIOUS PHYSICAL THERAPY EVALUATIONS OR THERAPIES?

- ☐ YES
- ☐ NO

IF YES, PLEASE DESCRIBE WHERE, WHEN, ACTIVITIES AND RESULTS OF THERAPIES:

Is your child current receiving additional therapies?

- ☐ Yes
- ☐ No

If yes, which additional therapies does your child receive?

- ☐ Speech therapy
- ☐ Occupational Therapy
- ☐ ABA (Behavioral Therapy)
- ☐ Psychotherapy
- ☐ Vision Therapy
- ☐ Nutrition program
- ☐ Other: _____

If yes, Where and when?

Does your child attend school or daycare?

- ☐ Yes: _____

  Facility Name Teacher Phone Number
- ☐ No

Does your child have an Individualized education plan?

- ☐ Yes; services received _____
- ☐ No

Has Your teacher expressed any concerns regarding your child?

- ☐ Yes; please explain _____

  _____
- ☐ No

To the Best of your ability, please outline your child's daily schedule

BIRTH HISTORY

Please Describe any complications during pregnancy (i.e. diabetes, preeclampsia)

Type of Delivery:

- ☐ Vaginal
- ☐ C-Section

Please indicate any birth complications:

- ☐ Premature Birth
- ☐ Emergency C-Section
- ☐ Forceps or Vacuum
- ☐ Breathing Difficulties
- ☐ Jaundice
- ☐ Feeding Difficulties
- ☐ Incubation
- ☐ Tube Feeding
- ☐ Low APGAR
- ☐ Congenital Defects
- ☐ Other: _____

Name of Hospital or Birthing Location: _____

Weeks gestation: _____

Birth Weight: _____ Birth Length: _____

Mother's Age of time of Birth ____ Father's Age of time of Birth _____

NICU Stay?

- ☐ Yes: _____ Days/Weeks/Months
- ☐ No

MEDICAL HISTORY

Please List Any Documented Medical Diagnoses: _____

Does your child have a history of any of the following?

- ☐ Allergies
- ☐ Anemia/Blood Disorder
- ☐ Asthma
- ☐ Bone Disorder
- ☐ Botox
- ☐ Concussions
- ☐ Constipation or Diarrhea
- ☐ Failure To Thrive
- ☐ Fractures (Broken Bones)
- ☐ Feeding Problems
- ☐ Frequent Colds
- ☐ Frequent ear infections
- ☐ Genetic Disorder
- ☐ Head Injuries
- ☐ Hearing Loss
- ☐ Heart Condition
- ☐ Hormonal Concerns
- ☐ Joint Disease
- ☐ Kidney Disorder
- ☐ Muscle Disorder
- ☐ Neurological Disorder
- ☐ Respiratory Illness
- ☐ Seizures or Convulsions
- ☐ Skin Concerns
- ☐ Stomach/GI Disorders
- ☐ Trauma History
- ☐ Urinary Tract Infections or Urinary difficulties
- ☐ Vision Concerns
- ☐ Vomiting
- ☐ Other: _____

BELL PHYSICAL THERAPY
PERFORMANCE & WELLNESS

PREVIOUS IMAGING OR SPECIAL TESTING, DATES, & RESULTS

PRIOR MEDICAL PROCEDURES OR SURGERIES

PLEASE LIST ANY MEDICATIONS:

_____

_____

_____

HAS YOUR CHILD RECEIVED ALL OF THE VACCINATIONS RECOMMENDED BY YOUR PEDIATRICIAN

- ☐ YES
- ☐ NO; PLEASE EXPLAIN: _____

DEVELOPMENTAL HISTORY

HOW OLD WAS YOUR CHILD WHEN HE/SHE FIRST:

ROLLED OVER:

CRAWLED:

WALKED INDEPENDENTLY:

SPOKE IN SENTENCES:

SAT INDEPENDENTLY:

PULLED TO STAND:

SPOKE SINGLE WORDS:

DOES YOUR CHILD REQUIRE ASSISTANCE WITH:

TAKING ON AND OFF SHOES?	___YES	___NO
PULLING UP/TAKING OFF PANTS?	___YES	___NO
PUTTING ON/TAKING OFF SHOES?	___YES	___NO
IS YOUR CHILD POTTY TRAINED?	___YES	___NO

DOES YOUR CHILD HAVE A HISTORY OF DIFFICULTY WITH FEEDING OR WEIGHT GAIN?

PLEASE EXPLAIN:

- ☐ YES; PLEASE EXPLAIN _____
  _____
- ☐ NO

PLEASE DESCRIBE YOUR CHILD'S SLEEP ROUTINES AND TIMES (NAPS AND BEDTIME)

DOES YOUR CHILD EXPERIENCE DIFFICULTY FOLLOWING DIRECTIONS AT HOME?

- ☐ YES
- ☐ NO

PLEASE DESCRIBE ANY BEHAVIORAL CONCERNS

WHAT DOES YOUR CHILD ENJOY?

ADDITIONAL COMMENTS: _____
_____
_____
_____
_____

I HAVE COMPLETED THIS FORM TO THE BEST OF MY ABILITY AND DISCUSSED THE INFORMATION WITH DR. BELL. I UNDERSTAND THAT DR. BELL IS RELYING UPON THIS INFORMATION TO MAKE TREATMENT RECOMMENDATIONS.

_____ _____
CHILD NAME DATE

_____ _____
PARENT/GUARDIAN NAME PARENT/GUARDIAN SIGNATURE

BELL PHYSICAL THERAPY
PERFORMANCE & WELLNESS

Physical Therapy Consent to Treatment

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, disability or sexual orientation.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them. Response to physical therapy intervention varies from person to person; hence, it is not possible to predict your response to a specific modality, procedure, or exercise protocol. Bell Physical Therapy does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain, injury, or other symptoms.
It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned and to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. If I am a parent, I give Bell Physical Therapy consent to treat my child.

_____ _____

CHILD NAME DATE

_____ _____

PARENT/GUARDIAN NAME PARENT/GUARDIAN SIGNATURE

HIPAA Agreement

I consent to the use or disclosure of my protected health information (PHI) by Bell Physical Therapy for the purpose of treatment, payment, and health care operations. By signing this agreement, I verify I have read the Health Insurance Portability and Accountability Act (HIPAA) and am aware of my rights as a patient at Bell Physical Therapy. If you wish to obtain a copy of the HIPAA Privacy Act for your own records, it can be found at: https://www.hhs.gov/sites/default/files/privacysummary.pdf

_____ _____

CHILD NAME DATE

_____ _____

PARENT/GUARDIAN NAME PARENT/GUARDIAN SIGNATURE

Payment Agreement

I agree to be responsible for full payment of my bill due to Bell Physical Therapy. I understand that Bell Physical Therapy accepts payment in the form of credit card, check, cash, or digital payments using the platforms Zelle and Venmo. All payments shall be received within 1 week of services provided.

If a session is canceled by the patient less than 24 hours prior to the scheduled treatment time, the patient will be charged a 25$ cancelation fee.

_____ _____

CHILD NAME DATE

_____ _____

PARENT/GUARDIAN NAME PARENT/GUARDIAN SIGNATURE