Children's Rehab Services of Western New York

DIVERSIFIED Rehabilitation Services

First Name: _____ Middle Name: _____ Last Name: _____

Address:_____ Apt/Unit:_____

City:_____ State:_____ Zip::_____

Date of Birth: ____/____/_____ Gender: _____ Last 4 of Social Security #: ____ ____ ____

Home Phone #: _____ Cell #: _____E-Mail: _____

Emergency Contact: _____ Phone#:_____ Relationship:_____

Primary Doctor:_____ Phone #: _____

Referring Doctor:_____ Phone #: _____

Do you have a follow-up scheduled at your referring physician? ___Y ___N If yes, when:_____

Do you live in a Skilled Nursing or Assisted Living Facility, or Rehab Center? Y _ N_ name/phone:_____

Consent for Treatment

The patient/legal guardian authorizes The American Institute of Balance staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

Consent to Release Medical Information

I authorize Diversified Rehabilitation Services to release any information acquired in connection with my diagnostic/treatment services including, but not limited to, diagnosis & clinical records, to myself, my insurance(s), physician(s), and _____

Assignment of Insurance Benefits

I hereby authorize payment to be made directly to Diversified Rehabilitation Services.

Primary Insurance Name _____ ID # _____ Group # _____

Primary Insurance Card Holder Name _____ Primary Card Holder Date of Birth ___ / ___ / ___

Secondary Insurance Name _____ ID # _____ Group # _____

Initials

Guarantee of Payment: I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when a patient does not call to cancel an appointment, he/she is preventing another patient from getting much needed assistance. Out of this necessity, if an appointment is not cancelled by 4 PM the day preceding the scheduled appointment, a twenty-five dollar ($25) fee will be charged; this will not be covered by your insurance company. Thank you for understanding

I hereby certify that I understand these rights as set forth

I acknowledge that I have been informed of Diversified's Privacy Practices as required by the Health Insurance Portability And Accountability Act (HIPAA). I have the option to request full details regarding the privacy of my information. A current copy of our Privacy Practices is available to you upon request. I further understand that I am concenting to receive emails and/or voice message unless otherwise stated.

Client/Responsible Party Signature: _____Date:_____

Legal Representation (If applicable): Name:_____ Signature:_____

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DIVERSIFIED REHABILITATION SERVICES

PEDIATRIC CASE HISTORY FORM

Patient Name: _____ Age: _____ Date of Birth: _____

Referring Physician: _____

Diagnosis: _____ Date of Onset: _____

Areas of concern: **check all that apply*

Speech Articulation (pronouncing sounds/words)	Feeding/Swallowing	Fine Motor (handle small items with fingers)
Receptive Language (following directions, understanding language)	Play Skills	Hand-writing
Expressive Language (forming sentences, expressing self)	Reading	Sensory
Social Skills	Attention	Gross Motor (sitting, walking, throwing, jumping)
Stuttering	Behavior	Difficulty turning head
Voice	Unable to sit still	Frequent falls/clumsy

Describe your concerns and goals for therapy: _____

_____

Pregnancy/Birth History:

Pregnancy: Normal Abnormal/Complications (explain) _____

_____

Delivery: Vaginal Cesarean Birth weight: ____lbs. ____ oz. Premature: No Yes # of weeks born at: _____

Postnatal History: Jaundice Required Oxygen Other: _____

Physical Abnormalities: _____ Feeding/Swallowing Problems: _____

Birth Injuries: _____

Medical History:

Is your child taking medicine? Yes No

List medications:_____

Is your child allergic to any of the following? latex food medication other If yes, *list*_____ no

* Has your child had any of the following?

Surgery/hospitalization	Heart problems	Vision problems	Seasonal allergies	Diabetes	Movement limitations
Serious accident/injury	Digestive problems	Hearing problems	Ear infections	G-Tube	Frequent falls
Chronic illness	Breathing problems	Swallowing problems	Tubes in Ears	Seizures	Joint problems
Genetic disorder/Syndrome	Neurological problems	Sleeping difficulties	Acid Reflux/GERD	Body pain	Other

***Please explain any checked items here:* _____

_____

Vision/Hearing:

Has the child had a hearing test? Yes No Results? _____

When? _____ Where? school Physician Audiologist ENT hospital

Recommendations? audiological evaluation hearing aid cochlear implant other _____ none

Has the child had a vision test? Yes No Results? _____

Does your child wear glasses? Yes No

Developmental Milestones:

Developmental Skill	Age Achieved	Developmental Skill	Age Achieved
Lift head while on tummy		Stand alone	
Roll		Walk	
Sit alone		Babble	
Hold toys while sitting		First word	
Crawl on tummy/crawl on all fours/scoot on bottom		Put 2 words together	
Walk sideways using furniture		Taken off bottle/breast	
Potty trained			

Pediatric History Form (page 2)

Patient Name: _____

Speech & Language:

Language(s) besides English spoken in the home? Yes No If yes, what language(s)?_____
Language child understands best?_____ Language child speaks most often?_____
How does your child communicate the majority of the time? pull you to object gesture/point make sounds words phrases sentences sign language communication book communication device other_____
What does your child understand? *Check all that apply.* simple directions 2-step directions wh- questions yes/no questions conversation
How much can the parents understand of their speech? all most some none
How much can others understand of their speech? all most some none
List sounds that your child has trouble pronouncing:_____

Feeding History:

Does the child have trouble swallowing?	Yes	No	Does child have difficulty chewing?	Yes	No
Has the child had a swallow study?	Yes	No	Avoids certain food textures/temperatures?	Yes	No
If yes, list results/recommendations: _____			Sensitive in/around mouth/face/head	Yes	No
Is the child a "picky" eater?	Yes	No	Does the child drool?	Yes	No
Is the child a messy eater?	Yes	No	Was weaning a problem?	Yes	No

Family History:

Who is your child's legal guardian? parents mother father other, *list name and relationship*_____
Marital status of parents: single married separated divorced widowed Is your child adopted? Yes No
List everyone in the child's primary household: _____
#of adults in the home: _____ # of children in the home: _____ Ages of children: _____
What does your child spend most of his time at home doing? _____
_____
Have any relatives had developmental delays, physical problems or learning disabilities/disorders? If yes, *please list*. _____
_____
Are there stairs in the home? Yes No If yes, how many? _____ Is there a handrail? Yes No

School History:

Does your child attend a day care or school? Yes No If yes, where? _____
What is their current grade level? _____ Does your child have an aide? Yes No
Has your child repeated a grade? Yes No If yes, what grade? _____
Are they in a special program or class? Yes No If yes, *list* _____
Does your child receive therapy at school? Yes No If yes what? PT OT Speech Vision
What's your child's biggest difficulty at school? Particular Subjects(s), *list*_____
PE getting along with peers conduct/behavior other,_____
On average, what are your child's grades? A's (90-100) B's (80-89) C's (70-79) F's (below 70)

Other:

Has your child seen any of the following professionals?

Geneticist	Neurologist	Developmental Pediatrician	Physical Medicine Rehabilitation Physician
ENT	Orthotist	Behavioral Therapist	Speech-Language Pathologist
Other	Psychologist	Physical therapist	Occupational therapist

If you checked yes to any of the following, please list the name of the professional, when they were seen, and if applicable the resulting diagnosis:
_____
_____

Below is a list of words which describe a child's personality or behavior. Please circle those which you feel tend to describe your child:

Shy	Hard to discipline	Very Active	Toe walker
Happy	Has temper tantrums,	Independent	Frequent faller
Moody	how often? _____	Dependent	Slow moving
Friendly	Fights with peers/siblings	Leader	Easily frustrated
Clumsy/awkward	Even tempered	Follower	Overly sensitive to touch/sound/smells
Nervous/anxious	Has trouble sleeping	Prefers to be alone	
Perfectionist	Sucks thumb/pacifier	Quiet	

_____ _____
Parent/Guardian Signature Date

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Patient Name: _____ Date: _____

Please list all of your child's **current medications and supplements**

Prescription	Dosage	Frequency	Route	Reason

Over the counter	Dosage	Frequency	Route	Reason

Supplements & Vitamins	Dosage	Frequency	Route	Reason

Patient Name: _____ Date of Birth:_____

Use this section to let us know any other information that you feel is pertinent

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