littlefield therapy

phone/fax: (855) 454-3784

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Formulario de Admisión de Paciente		
Nombre del Paciente:(Apellido, Primer nombre, Inicial de nombre mediante)	Fecha de Nacimiento:	Sexo:
Domicilio:	Ciudad, Estado:	Código Postal:
Número de Teléfono:	Número de Teléfono Secundario:	Correo Electrónico:
Padre/Guardián Legal:	Relación al paciente:	
Padre/Guardián Legal:	Relación al paciente:	
Coordinador de servicios, si applicable:		
Información de Doctor Médico		
Médico Referente:	Médico Primario, si diferente a médico referente:	
Domicilio:	Ciudad, Estado:	Código Postal:
Teléfono:	Fax:	Diagnostico Médico:
Información de Aseguranza/Persona Responsable de Pago		
Compañía de Aseguranza:	Número de Identificación de Miembro:	Número de Grupo:
Grupo Médico (IPA) solamente para planes de HMO:	Teléfono para Servicios de Proveedor:	Fax para Servicios de Proveedor:
Nombre del Asegurado Principal: (Apellido, Primer nombre, Inicial de nombre mediante)	Fecha de nacimiento:	Número de Seguro Social:
A quien podemos agradecer por referir?		

Nombre: _____ Fecha de Nacimiento:____/____/____ Diagnóstico: _____ PDC: _____

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Liberacion de Informacion / Release of Information

Esto autoriza a, Littlefield Therapy Inc., para proporcionar una copia, sumarias o narrativa del historial médico, archivos médicos y por la liberación de la información (verbal, contacto telefónico, evaluaciones escritas, informes de progreso, informes médicos y/o evaluaciones médicas) con respecto a (Paciente) _____ , a partir de hoy ____ / ____ / ____ hasta su descarga. A menos de que se especifique lo contrario. Autorizo la divulgación de información entre Littlefield Physical Therapy Inc. y:

This authorizes, Littlefield Physical Therapy Inc., to provide a copy, summary or narrative of medical records and for the release of information (verbal, telephone contact, written evaluations, progress reports, medical reports and/or medical evaluations) regarding (Patient) _____, from today ____/____/____ through discharge. Unless otherwise specified. I authorize the release of information between Littlefield Physical Therapy Inc. and:

Por favor indique todos y todas las que apliquen o por lo contrario la información no podrá ser divulgada.
Please list any and all that apply otherwise information may not be released.

Padre/Guardián legal (Parent/Legal Guardian):
Parientes adicionales (Additional Family Members):
Enfermera/Vigilante (Nurse/Care Taker):
Médico Primario (Primary Physician):
Especialista (Specialist):
Compañía de Aseguranza (Insurance Company):
Centro Regional (Regional Center):
Representante de CCS (CCS Representative):
Vendedor de Equipo Médico Duradero (DME) (DME vendor):
Ortesis (Orthosis):
Otro (Other):

Por favor indique todos los individuales a quienes no podemos divulgar información y agregue documentación.
Please list any individuals we are legally not allowed to release information to and attach documentation:

Nombre/s - Name(s):

_____ _____ _____

Firma Relación al paciente Fecha

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Hemet, CA 92545

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Suite 101
Murrieta, CA 92562

27525 Enterprise Circle West
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POLÍTICAS DE LA OFICINA

Iniciales	
	Gracias por escoger a Littlefield Physical Therapy! **Esperamos participar plenamente en todas sus sesiones. Mantenga las líneas de comunicación abiertas.** Por favor mantenganos al tanto de problemas nuevos al comienzo de cada sesión. Tomamos muy enserio su salud y su confianza en nosotros.
	Damos la bienvenida a su llegada anticipada. Por favor ingrese y comience los ejercicios o actividades en nuestra facilidad.
	PROGRAMACIÓN DE CITAS. Hacemos todo lo posible por atender sus preferencias. Hable con nuestro personal sobre sus necesidades para programar sus citas. Su consistencia en mantener todas sus citas programadas es crítico a la rehabilitación y éxito del programa. Por favor, de dar una noticia mínima de cancelación de 24 horas. **Después de 3 cancelaciones de último minuto o faltas sin aviso en un periodo de 30 días el paciente será puesto en una programación flexible.**
	El paciente/padre legal serán responsables por conseguir cualquier reembolso por sus sesiones de terapia. Es la responsabilidad del paciente/padre legal saber su cobertura de aseguranza, por ejemplo la cantidad de visitas autorizadas por año. El paciente deberá obtener cualquier autorización necesaria para sus servicios. Pedimos que comunique a Littlefield Physical Therapy si tiene alguna pregunta o problema referente a un reembolso. Mi deducible es: _____ Mi Copago es: _____ Las limitaciones de visitas son: _____
	Por fondos insuficientes o cheques sin fondos devueltos, Littlefield Physical Therapy hará un cobro de $25 adicionales por articula devuelto.
	Referencias médicas para terapia física, ocupacional, y de habla son necesarios en la mayoría de los casos. Por favor hable con su médico regularmente referente a las terapias o si ocupa asistencia en obtener nuevas referencias o referencias modificadas cada seis meses o cada cuando su terapista lo recommiende. Estamos dispuestos en asistir si es que tiene dificultad y ocupa ayuda en obtener una autorización.
	Consentimiento para tomar fotografía/video: Yo **AUTORIZO / NO AUTORIZO (por favor circule uno)** el consentimiento para fotografiar o tomar video de _____ **(Nombre del paciente)** para motivos educacionales, médicos, y/o motivos de anuncios.
	He recibido una copia de la Ley de Responsabilidad y Portabilidad del Seguro de Salud (HIPAA) de Littlefield Physical Therapy.
	Estamos comprometidos al futuro éxito de nuestras terapistas. En consecuencia, estudiantes y voluntarios participan en nuestras sesiones. Por favor hable con su terapista si tiene alguna preocupación sobre la participación e involucración de nuestros estudiantes o voluntarios.
	Pido que pagos autorizado de _____ **(nombre de compañía de aseguranza)** de beneficios sean pagados en nombre de _____ **(nombre del paciente)** a la proveedora/facilidad: Melissa Littlefield y/o Littlefield Physical Therapy Inc. por servicios recibidos de parte de este proveedor. Acepto pagar copagos, coseguros y deducibles aplicables al momento del servicio recibido a menos de que haya otro acuerdo o arreglo de pago.
	Melissa Littlefield es la única propietaria de Littlefield Physical Therapy, de acuerdo con las normas éticas; no endosamos POPTS (Physician Owned Physical Therapy Services). Cualquier pregunta o preocupación puede ser dirigida directamente a Melissa Littlefield.
	Solicito una copia de la notificación de la Ley de Responsabilidad y Portabilidad del Seguro de Salud (HIPAA). YES / NO

_____ _____ _____

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PHOTO RELEASE

For good and valuable consideration, the receipt of which is hereby acknowledged,

I, _____, hereby authorize Littlefield Physical Therapy permission to use my child(rens) likeness in a photograph/video in any and all of its publications, including but not limited to all Littlefield Physical Therapy' printed and digital publications. I understand and agree that any photograph using my child(rens) likeness will become property of Littlefield Physical Therapy and will not be returned.

I acknowledge that since my participation with Littlefield Physical Therapy is voluntary, I will receive no financial compensation.

I hereby irrevocably authorize Littlefield Physical Therapy to edit, alter, copy, exhibit, publish or distribute this photo/video for purposes of publicizing Littlefield Physical Therapy's program or for any other related, lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my child(rens) likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph.

I hereby hold harmless and release and forever discharge Littlefield Physical Therapy from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

Print Client's Name: _____ Date:_____

Client's Signature: _____Date:_____

(*Signature of parent/guardian if under 18 years of age)*

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Speech Therapy Caregiver Questionnaire

Name of person completing questionnaire: _____ Relationship to child: _____
Names and ages of family members living with child: _____
Languages spoken at home (other than English): _____
Family member(s) who have had a speech-language deficit: _____
Reason for visit: (What are your speech and language concerns for your child?) _____

MEDICAL HISTORY

Length of pregnancy: Gestational Age/Weeks: _____
Was the delivery: Vaginal / Cesarean Section
Were there any complications during pregnancy? YES / NO
If yes, please circle: diabetes / excessive vomiting / weight loss / measles / bleeding / High blood pressure / swelling toxemia / breech birth / twisted cord / bruises / scars / Forceps / jaundice / blue / lack of oxygen
other: _____
Were there any problems during delivery? YES / NO
If yes, please circle: excessive blood loss / premature rupture of membranes / other: _____
Birth Weight:_____ Birth Height:_____ Current Weight:_____ Apgar Score:_____/10 @ 1 minute, _____/10 @ 5 minutes
Immediately following birth (circle if applicable): Feeding difficulties / Swallowing difficulties / Seizures
List any hospitalizations (reason and date): _____
List any medications that are currently being taken: _____
List any allergies or special diet currently being followed: _____
Other conditions and onset date (e.g. Autism – July 2010): _____

DEVELOPMENTAL HISTORY

Please note the appropriate ages at which your child accomplished the following milestones:

Sat independently hands free:	months	Walked independently:	months	Said first word:	months
Named people or objects:	months	Used two word sentences:	years	Use of complete sentences:	months

Did speech learning/development ever seem to stop for a period? YES / NO
If yes, please describe: _____

HEARING STATUS

Has your child's hearing been tested?	YES NO	If yes, please indicate date and facility:
Does your child have a history of ear infections?	YES NO	If yes, please indicate how many:
When was the most recent ear infection?		

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Does your child have P.E. tubes or hearing aids?	YES NO	

MOTOR SKILLS STATUS

Gross motor difficulties (walking)	YES NO	If yes, please describe:
Fine motor difficulties (writing)	YES NO	If yes, please describe:
Does your child walk on his/her toes often?	YES NO	If yes, please describe:
Does your child trip or fall often?	YES NO	If yes, please describe:

SENSORY SKILLS STATUS

Sensitivity to noise (e.g. music, crowds, etc…)	YES NO	If yes, please describe:
Sensitivity to textures (e.g. grainy) or clothes (socks, tags)	YES NO	If yes, please describe:
Sensory seeking (e.g. touching others or seeking pressure)	YES NO	If yes, please describe:
Atypical/inappropriate behaviors (e.g. self-stimulation, hand flapping, difficulty transitioning from one activity to another)	YES NO	If yes, please describe: _____

SCHOOL/SOCIAL HISTORY

Does your child attend school?	YES NO	If yes at what age did he/she begin?
What type of school is your child enrolled in?	Please circle one	Preschool / Public / Private / Homeschool
What type of classroom is he/she in?	Please circle one	Regular / Special Education / Special Day / Class Resource
Have any grades been repeated?	YES NO	If so, which grade(s)?
Does your child have difficulty in any particular subjects?	YES NO	If so, which one(s)?
Does your child get along with others at school?	YES NO	
Does your child have difficulty making friends?	YES NO	

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Does your child play and communicate well with his/her family/friends?	YES NO	If no, please describe:
Does your child participate in conversation?	YES NO	
Does your child maintain topic of conversation?	YES NO	
Does your child get teased about his/her speech problem?	YES NO	
Does your child make appropriate eye contact?	YES NO	

Does your child receive any of the following services at school?

YES NO	Speech Therapy: (please indicate type, times per week, and dates enrolled)
YES NO	Occupational Therapy: (please indicate type, times per week, and dates enrolled)
YES NO	Physical Therapy: (please indicate type, times per week, and dates enrolled)
YES NO	Adaptive PE: (please indicate type, times per week, and dates enrolled)
YES NO	ABA: (please indicate type, times per week, and dates enrolled)

Does your child work with any other speech-language pathologist? If so, where and what goals were targeted? _____

Does your child have an IEP? YES / NO (If yes, please provide a copy)

SPEECH STATUS

How does your child typically communicate with others? (Please circle)
babbling / facial Expressions / crying / gestures / pointing / signs / talking (whether understandable or not)

What sounds have you heard your child use?

Vowels: (Long)	a	e	i	o	u	(Short)	a	e	i	o	u	
Consonants:	p	b	w	t	d	n	f	v	k	g	h	s
	Z	sh	ch	j	y	l	r	th				

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Approximately how much of your child's speech do you understand? (Please circle) Less than 25% 25% 50% 70% 100%
Can people outside the family understand your child's speech? YES / NO
Did speech learning ever seem to stop for a period? YES / NO If yes, please describe when: _____
Describe the child's speech-language problem and at what age it began? _____
Has the problem changed since it was first noticed? If so, how has it changed? _____
Is the child aware of the problem? If yes, how does he/she feel about it? _____
Has the child been seen by other specialists? (ST, OT, PT, psychologist, etc…) Indicate specialist type and dates: _____

_____

___

PRAGMATIC/SOCIAL COMMUNICATION/BEHAVIOR (Circle all that apply)
interacts well with children,adults / imitates actions,gestures,speech / tries new activities / plays alone / separation difficulties / shy
poor eye contact / aggressive / self-abusive behaviors / eye contact / greetings (hi/bye) / reduced or lack of attention of others frustrates easily / difficulty staying on task / inattentive / very active / tantrums / makes requests / refuses to perform tasks
turn taking / pretend play / uses toys appropriately / responds to yes/no questions

List any concerns regarding social language/behavior: _____

_____

RECEPTIVE LANGUAGE (Circle all that apply)
responds to name / follows directions / understands basic vocabulary / points to pictures/common objects joint attention
hands a toy or object requested / follows simple directions / understands what you are saying

Please list any of your current concerns regarding your child's receptive language: _____

EXPRESSIVE LANGUAGE (Circle all that apply)
nonverbal / babbling / using words to communicate / label items / signs / asks questions / uses age appropriate vocabulary
answers simple questions

How many words does your child use now? (Please circle) 0-20 21-50 51-100 more than 100
If your child uses phrases or sentences, how long are they on average? (Please circle) 1 word 2-4 words 5 words more than 5 words

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