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Patient Intake Form		
Patient Name: (Last, First, Middle Initial)	DOB:	Sex:
Address:	City, State:	Zip:
Primary Phone:	Secondary Phone:	Email:
Parent/Legal Guardian:	Relationship to Patient:	
Parent/Legal Guardian:	Relationship to Patient:	
If applicable, Service Coordinator:		
Physician Information		
Referring Physician:	Primary Physician, if different than referring:	
Address:	City, State:	Zip:
Phone:	Fax:	Medical Diagnosis:
Insurance Information/Responsible Party		
Primary Insurance Company:	Member ID Number:	Phone Number:
Secondary Insurance Company:	Member ID Number:	Phone Number:
Medical Group (IPA) HMO's only:	Provider Services Phone:	Provider Services Fax:
Primary Insured Name: (Last, First, Middle Initial)	DOB:	SSN:

Patient Name ______ Signature ______ Relationship to Patient ______ Date ______

Release of Information

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:

Please list any and all that apply otherwise information may not be released.

Parent/Legal Guardian:
Additional Family Members:
Nurse/Care Taker:
Primary Physician:
Specialist:
Insurance Company:
Regional Center:
CCS representative:
DME (durable medical equipment) vendor:
Orthosis:
Other:

Please list any individuals we are legally not allowed to release information to and attach documentation:

Name/s:

_______________________________ Signature

_______________________________ Relationship to Patient

_______________________________ Date

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OFFICE POLICIES

Thank you for choosing Littlefield Physical Therapy. We take your health and trust in us very seriously.

- **CONSENT FOR TREATMENT:** The undersigned does hereby authorize Littlefield Physical Therapy, Inc. consent to evaluate and/or provide medical treatment for the below mentioned patient by employees of Littlefield Physical Therapy, Inc.
- **ARRIVAL:** Upon your early arrival please sign-in and feel free to get started with exercises and activities in our facility. Therapy session are scheduled for 30-60 minutes long. **A 10 minute grace period after the scheduled appointment time is given.** Any arrivals beyond the 10 minute allowance will count as a no show.
- **PARTICIPATION:** Your participation and consistency in maintaining all scheduled appointments is critical to your rehabilitation and success. We enjoy keeping open lines of communication therefore should you have questions please bring them up with your therapist at the beginning of your session. *Please be advised that parents/guardians of children less than 16 years of age must stay on the premises during your child's treatment session.*
- **SCHEDULING**: We make every attempt to accommodate your preferences. We encourage you to speak to our staff regarding scheduling needs. Please allow a minimum of 24-hour notice for cancellations. **After 3 last-minute cancellations/no shows in a 90 day period the client will be moved to a flexible or same day schedule.**
- **ILLNESS:** If your child presents with an illness preventing him/her to attend day care/school or participate in activities, you will be asked to reschedule their appointment. (See back for details).
- **REFERRALS:** A doctor's referral for Physical, Occupational, and Speech Therapy is necessary in most cases. Please speak with your physician regularly regarding therapy and assistance in attaining new or modified referrals every six months or as requested by your insurance. We are happy to assist you in attaining a referral if you are having difficulty.
- **AUTHORIZATION OF PAYMENT:** Patients are responsible for the reimbursement of therapy sessions. I agree to pay the applicable co-pays, co-insurances and deductibles at the time of service unless other arrangements have been made. It is the patient's responsibility to know their insurance coverage. Patients should ensure necessary authorizations are obtained and are encouraged to work with Littlefield Physical Therapy, Inc. regarding any reimbursement issues.
  - For non-sufficient funds/returned checks, Littlefield Physical Therapy will charge a **$25.00 fee** per item.
- **LIABILITY:** I know and agree that Littlefield Physical Therapy, Inc. is not responsible for lost or damaged personal items.

I would like a copy of the Privacy Practice, Health Insurance Accountability Act (HIPAA) regulations notice. YES / NO (Circle One)
By my signature, I acknowledge that I have read, understand, and agree to the Office Policies of Littlefield Therapy.

_______________	_______________	_______________	_______________
Patient Name	Signature	Relationship to Patient	Date

***We are committed to the future excellence of therapists. Consequently, interns, students and volunteers participate in our sessions. Please speak with your therapist if you are concerned with student and/or volunteer involvement.*

***Melissa Littlefield is the sole owner of Littlefield Physical Therapy. In keeping with ethical standards we do not endorse POPTS (Physician Owned Physical Therapy Services). Any questions or concerns can be directed to Melissa Littlefield.*

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SICK POLICY

In order to ensure the health of your child and other children that we serve we request that parents/caregivers cancel therapy sessions for the following communicable illnesses as soon as symptoms appear. Any illness preventing you or your child to attend day care/school or participate in activities including one or more of the following conditions:

- Fever of 100 degrees or over, within 24 hours of a visit
- Vomiting or diarrhea within 24 hours of a visit
- Contagious Conditions: Influenza (flu), Cold, Pink eye, Head lice, Rashes

This policy also applies to siblings in the waiting area of our clinic. If you are unsure if your child's condition is contagious, please consult your doctor before his/her session. Although some illnesses seem less severe than others, they can be detrimental to our medically fragile patient population. If they need a doctor's note to return to school or activity, we kindly request that you provide that for their medical record as well.

By my signature, I acknowledge that I have read, understand, and agree to the Sick Policy of Littlefield Therapy.

____________	____________	____________	________
Patient Name	Signature	Relationship to Patient	Date

**Effective 11/1/2016

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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	Used 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:

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When was the most recent ear infection?		
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	
Does your child play and communicate well with	YES NO	If no, please describe:

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his/her family/friends?		
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				

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? ____

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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

COMMUNICATION (Circle all that apply)
Sign Language Picture Exchange Communication System (PECS)
iPad + software (indicate application/system____
Speech Generating Device (indicate application/system____

Has your child received an Alternative and/or Augmentative Communication Assessment YES / NO
If yes, please describe when & where: ____
If yes, please provide a copy of the evaluation at time of this assessment for the therapist to review and incorporate as appropriate.

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