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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:

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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.
  - My deductible is: __________ My Co-pay is: _________ Visit limitation per year is: __________
  - I request that payment of authorized ____________________ **(insurance company name)** benefits be made on ____________________ **(patient's name)** behalf to the following provider/facility: Melissa Littlefield and or Littlefield Physical Therapy, Inc. for any services rendered by this provider.
  - For non-sufficient funds/returned checks, Littlefield Physical Therapy will charge a $25.00 fee per item.

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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Feeding/Swallowing History Questionnaire

What concerns do you have about your child's eating that you would like help with at this visit?
What do you hope to gain from this appointment?

I. GENERAL HISTORY

Does your child have any of the following symptoms when eating or drinking? (Please check all that apply.)

gagging/coughing on textures
choking
vomiting
limited volume/not eating enough
eats a limited variety of food/selective
difficulty swallowing
slow weight gain
refuses to swallow/holds food in mouth
refuses to eat
difficulty progressing to table food
Repeated respiratory infections
Recurrent pneumonia
chronic low grade fever
weight loss/failure to thrive
Cleft lip/palate
vocal cord paralysis
visual or hearing deficit
Tube feeding
tracheostomy
excessive drooling
reflux (spitting up/vomiting)
nasal regurgitation
mealtimes more than 30 minutes
other (please describe): ____

At what age did your child's eating first become a concern? ____________________

What strategies have you tried to deal with your child's eating problems?

distraction during meals (e.g. games, TV)
forcing
skipping meals
allowing child to drink more fluids
rewards
giving preferred foods
feeding child when s/he requests food
punishment
coaxing
high calorie supplements/formula
other (please describe):____

Does your child have any physical pain while (associated with) eating or drinking? Yes No

If Yes, please circle your child's usual level of pain/discomfort with eating or drinking on the scale below:

None			Mild			Moderate			Severe	
0	1	2	3	4	5	6	7	8	9	10

II. BIRTH HISTORY

Was your baby born within 2 weeks of his/her due date? Yes No

If not, at how many weeks gestation was the baby born? ___________________

How much did your baby weigh at birth? ________________ Born by: vaginal caesarian section

Did you have any of the following problems with pregnancy, labor, or delivery:

gestational diabetes preterm labor eclampsia/pre-eclampsia

abnormal ultrasound infection other (specify)____

Please describe:____

Did your baby have any of the following problems in the nursery:

Gastroesophageal reflux (GER) mechanical ventilation bronchopulmonary dysplasia (BPD)

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apnea CPAP therapy necrotizing enterocolitis (NEC)
feeding and growth issues tube feedings intraventricular hemorrhage (bleeding in brain)
other (specify) ______________________________
Please describe: ____
How long did your baby stay in the nursery? ____

III. MEDICAL HISTORY

Please note any of your child's medical, developmental and/or mental health diagnoses.

GE reflux failure to thrive/slow growth developmental delay esophagitis
pulmonary (lung) issues (asthma) cardiac (heart) issues neurologic (brain)issues
slow stomach emptying constipation renal (kidney) issues eosinophilic
esophagitis diarrhea Fundoplication

autism/PDD mental health (specify)____
Genetic/chromosome abnormality (specify) ____
other (specify) ____
How often does your child have a bowel movement? daily every other day
other ____
Does s/he have issues with: Constipation (hard stools) Yes No Diarrhea (loose stools) Yes No
Does your child have any allergies? Yes No
If yes, please indicate:
food ____
medication ____
contact ____________________ seasonal / environmental ___________________________________
contrast dyes ________________ adhesives/tape ____

IV. PEDIATRIC CARE

Does your child currently see any specialists? Yes No - If yes, please list below:
Name of Specialist Specialty Location Date last seen
Does your child see a dietitian / nutritionist? Yes No – name: _________________________________
Have any of the following medical tests been done?

upper GI series milk scan modified barium swallow study
endoscopy pH probe genetic (chromosome) testing
head CT scan head MRI scan bone age film/x-ray
allergy testing other (specify) ______________________
Location & Date of Testing: ____

Please list your child's current medications. (Include vitamins and other over-the-counter medications): ________________________
Medication Dose How often:____
Has your child ever been hospitalized or required surgery? Yes No
If yes, please explain and give dates:____
Are your child's immunizations up to date? Yes No
What was your child's weight at his/her most recent visit with the primary doctor? ______________

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(Please bring record of weight/growth history if available)

V. FAMILY HISTORY:

Are there medical problems that run in the family? (Parents, siblings, grandparents?) Please indicate:

Cystic fibrosis	Celiac sprue disease	GE reflux
Lung disease	Crohn's disease	Ulcerative colitis
Stomach ulcers	Liver disease/cirrhosis	Spastic colon/irritable bowel
Thyroid disease	Allergies	Asthma
Developmental delay	Learning disabilities	Genetic abnormalities
Diabetes	Heart disease	Mental health

Other: (please specify) ____

VI. FEEDING HISTORY

How was your child fed as an infant? breast bottle

How long did your child receive breast milk? ____

Did your child have any difficulties with breastfeeding or bottle feeding? Yes No

If yes, please describe ____

How many infant formulas did you use? ____

Please list: ____

At what age did your child eat baby food from a spoon? _______________________________________

Did he/she have difficulty? Yes No

If yes, please explain: ______________________________

VII. EATING ENVIRONMENT

Where does your child usually sit during mealtimes?

infant seat	highchair	booster seat	chair at table
child stands	child wanders around	in front of TV	held in caretaker’s arms
on caretaker’s lap			

other ____

Where in the house is your child fed?

kitchen dining room living room walking around

other (please specify) _______________________________________

With whom does your child usually eat/drink?

alone with parents with siblings with peers with nurse

At what other locations does your child eat/drink?

daycare school other relative’s home in the car

Does your child do any of the following during a mealtime?

Refuse to eat	Tries to get out of seat	Spits out food	Falls asleep
Cries/screams	Gags/coughs	Vomits	Throws food/utensils
Holds food in mouth			

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VIII. CURRENT FEEDING/DRINKING SKILLS

Who feeds your child?

Mother Father Sibling Grandparent Nurse

Teacher Daycare provider other (please specify) ________________________

Please note your child's current feeding skills.

a. Spoon fed? Yes No If yes, type of spoon? ____

b. Child feeds self? Yes No

Finger feeding: beginning partially successful completely successful

Feeds self with spoon: beginning partially successful completely successful

c. Drinking from breast? Yes No

d. Drinking from a bottle? Yes No

If yes, what type of nipple: Regular orthodontic other (please specify)__________

e. How is your child positioned during feeding?

seated held other (please specify)______________________________________

f. When is bottle/breast offered? ____

g. Drinking from a cup? Yes No If yes, type of cup _______________________________________

h. Straw drinking? Yes No

What types of liquid does your child drink? ____

How much liquid does your child drink per day?

0-8 oz 8-16 oz 16-24 oz 24-32 oz 32-40 oz >40 oz

Food Textures

Please (X) your child's current ability to eat a variety of food textures:

Texture	Eats easily	Eats with Difficulty	Refuses/Cannot Eat	Never Tried
Baby food				
Puree table food				
Mashed table food				
Soft Finger Solids				
Chopped table food (e.g., Pancakes)				
Crunchy Table food (e.g., apple, crackers)				
Difficult to chew table food (e.g. meat)				

Please give examples of food your child will eat from all food groups (Food Group Examples)

Fruit ____

Grains (bread/cereal/ pasta/rice) ____

Vegetables ____

Meats/egg/peanut butter ____

Dairy (milk/cheese/yogurt) ____

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IX. TUBE FEEDING ASSESSMENT

Does your child receive tube feeds: Yes No (If not, please skip this section)?

What is the name and specialty of the Provider who tells you what to give through the tube?

____

Type of tube used: NG G G-J

Formula used: ____

Schedule: (Include times and amount given) ____

____

Other Information/concerns you would like to share regarding feeding/swallowing for your child:

____

____

*****Due to food allergies, all parents are requested to bring in liquid and solids/food items to the evaluation that your child will eat, items they prefer as well as other textures you are interested in evaluating. If your child has completed a Modified Barium Swallow Study (MBS), please attach a copy of the report to this form.*****

Thank you for completing this intake form as it allows us to assist your child's individual needs.

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