LAKE CENTRE for REHAB

NEW PATIENT INFORMATION SHEET & AUTHORIZATION
FOR PEDIATRIC PATIENTS

HOW DID YOU HEAR ABOUT US? ☐ PHYSICIAN ☐ WEBSITE ☐ FACEBOOK
☐ SEMINAR ☐ NEWSPAPER AD ☐ FRIEND ☐ RETURNING PATIENT ☐ OTHER_____

Name (First)_____(Middle)_____(Last)_____Age_____

Date of Birth_____Social Security Number_____ Gender: ☐Male ☐Female

Father's Name_____Mother's Name_____

Mailing Address_____

(City)_____(State)_____(ZIP)_____

Phone: Home_____Cell_____Work_____

Primary Phone _____Email Address_____

Father's Employer_____

Employer's Name, Address and Phone_____

Father's Date of Birth_____Social Security Number_____DL Number_____

Mother's Employer_____

Employer's Name, Address and Phone_____

Mother's Date of Birth_____Social Security Number_____DL Number_____

Patient was referred by_____

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- I, the undersigned, give permission for Lake Centre for Rehab to treat _____ for any and all physical, occupational or speech therapy treatments which may be deemed advisable by my child's attending physician, and grant authority to Lake Centre for Rehab to administer therapy in accordance with my child's physician's Plan of Care.

- I hereby authorize payment directly to Lake Centre for Rehab for medical benefits, if any, otherwise payable to me under the terms of my insurance. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR SERVICES NOT COVERED BY THIS AUTHORIZATION.

- I hereby authorize Lake Centre for Rehab to release any and all information concerning my child's medical condition to my insurance company, attorney or to the physician referring my child.

- I have had the opportunity to review the below-listed documents and agree to the contents of each:

  1. Authorization for Treatment, Assignment of Benefits, Payment Responsibility and Disclosure of ALF Resident Information.
  2. Acknowledgement of Receipt of Privacy Notice in combination with Voluntary Consent.

_____ _____
Patient Signature Date Witness Date

_____ _____
Parent Signature Date Relationship to Patient

LAKE CENTRE for REHAB

CASE HISTORY INFORMATION FORM FOR CHILDREN

I. IDENTIFICATION

Your child's full name_____ Date of birth_____

School_____ Grade_____ Age_____

Father's name_____ Home phone_____

Father's address_____ ZIP code_____

Father's occupation_____ Father's age_____ Work phone_____

Mother's name_____ Home phone_____

Mother's address_____ ZIP code_____

Mother's occupation_____ Mother's age_____ Work phone_____

Referred by_____
(Name) (Address)

Family physician_____
(Name) (Address)

Other children in family:

Name	Gender (M/F)	Age	Grade	Speech, Hearing or Medical Problem?

II. PRENATAL HISTORY

Birth weight_____ Length_____ Duration of pregnancy_____

Duration of labor_____ Type of delivery: ☐ Head first ☐ Feet first Breech ☐ C-section

Were there any complications during this pregnancy or birth? If so, describe_____

_____

_____

Please list any type of treatment received by the baby or mother_____

_____

III. DEVELOPMENTAL MILESTONES

Please provide approximate age the child began to do the following activities (if you are not sure of the age, please indicate whether you feel it was **normal** of **delayed**):

Physical milestones:

Turn head from side to side_____ Cruise (walk with support)_____

Lift head while lying on tummy_____ Walk alone_____

Roll over_____ Feed self_____

Sit alone without support_____ Dress self_____

Crawl/creep_____ Gain bowel control: Day_____ Night_____

Pull to a standing position_____ Gain bladder control: Day_____ Night_____

Speech milestones:

Chew_____ Combine 2 words_____3 words_____
(for example, me out, want drink, mommy go car)

Drink from a regular cup_____ Use simple questions_____
(for example, Where's Daddy?)

Babble_____ Engage in conversation_____
(for example, make sounds)

Name objects_____
(for example, tree, car, bird)

At what age did your child say his first words_____ What were they?_____

How does your child usually communicate with others? (Gestures, sounds, single words, phrases, sentences, other)____
_____

Is there a family history of speech, language and/or hearing problem? ___Yes ___No If yes, who?_____

Does your child have any feeding problems (including sucking, swallowing, chewing, drooling)?_____

Does your child fall, lose his/her balance easily or seem uncoordinated?_____

Please list any **medications** your child is currently taking_____

Please check (✓) any **medical conditions** your child has experienced:

_____Whooping cough	_____Mumps	_____Scarlet fever	_____Measles
_____Chicken pox	_____Pneumonia	_____Diphtheria	_____Croup
_____Influenza	_____Polio	_____Headaches	_____Sinus problems
_____Meningitis	_____Rickets	_____Rheumatic fever	_____Myringotomy
_____Earaches	_____Running ears	_____Chronic colds	_____Head injuries
(How many?_____)	_____Asthma	_____Allergies	_____Convulsions
_____Seizures	_____Encephalitis	_____High fevers	_____Typhoid
_____Tonsillitis	_____Tonsillectomy	_____Adenoidectomy	_____Mastoidectomy
_____Paracentesis	_____Dizziness		

Please list any diagnoses your child has received and by whom_____

_____

_____

Please list any major **accidents**, **hospitalizations** and/or **surgeries** your child has had_____

_____

_____

Do you think your child hears adequately? ___Yes ___No If no, please explain_____

_____

Has there been a change in your child's speech/language/hearing skills in the past six months? ___Yes ___No If yes, please explain_____

Please describe your child's problem(s)_____

_____

When was the problem first noticed?_____By whom?_____

Does your child seem to be aware of his/her speech or language problems? ___Yes ___No

Please list any special equipment your child uses for daily activities (for example, glasses, hearing aids, braces, wheel-chair, communication devices, etc.)_____

How would you like us to help you and child?_____

Has your child had any previous speech therapy? ___Yes ___No If yes, where?_____

IV. ADDITIONAL INFORMATION

Has your child had a previous speech/language/hearing, neurological, psychological, educational or other type of evaluation? ___Yes ___No

If yes, please state when the evaluation was provided, by whom and for what reason:

Type of Evaluation	When	By Whom	Reason for Evaluation	Results

If there is additional information you feel will help us to understand your child better, please describe_____

_____

Person completing this form_____

Relationship to child_____

Signature_____Date_____