Please bring prescription for therapy and
your insurance card to be copied. Thank you.



MOUNTAIN TOWN REHAB

## Pediatric Patient Information

Name: _____ Date of Birth: _____
(Last) (First) (MI) Weeks Gestation: _____

Home Address: _____
(Number & Street) (City) (State) (Zip Code)

Mailing Address (If different): _____

Home Phone: _____

Mom's Name: _____ Mom's Address: _____

Work Phone: _____ Cell Phone: _____

Dad's Name: _____ Dad's Address: _____

Work Phone: _____ Cell Phone: _____

Person responsible for co-pays/deductibles: _____

School/Day Care Contact: _____ Contact Phone: _____

Referred by: _____ Reason for Referral: _____ Date of Onset: _____

Person to notify in emergencies: _____ Relationship: _____ Phone Number: _____

Has patient had physical therapy this calendar year? ___ When: _____ Where: _____

## Insurance Information

If this injury is due to an automobile accident, please complete the information below:

Automobile Insurance Company: _____
Address: _____
Phone Number: _____ Date of Injury: _____
Contact Person: _____
Claim Number: _____

I hereby give **Mountain Town Rehab** permission to provide treatment as prescribed by the physician. I understand and agree that I am ultimately responsible for any co-payments and/or deductible or any professional services rendered that are not payable by my insurance company. I have completed the above questions and I certify that this information is true and current to the best of my knowledge. I will notify you of any changes in health status or the above information.

I authorize the release of any information pertinent to the case to any insurance company, adjuster or other medical person/entity, caregivers, and teachers/school personnel.

**Signature of Parent or Guardian**: _____ Date: _____

MOUNTAIN TOWN REHAB

**Name:** _____ **Date:** _____ **Date of Birth:** _____

**Physician:** _____ **Reason for Referral:** _____

## Birth Information

[] Full Term Pregnancy
Gestation Weeks: _____
[] Uncomplicated Pregnancy
[] Non Scheduled Vaginal Delivery
[] C-Section; Emergency or Scheduled
[] Multiple births; Number: _____

Birth weight: lbs _____ oz _____

Complications during pregnancy and delivery: _____

Were forceps or other assistive means necessary during delivery? _____

Did your child stay in the NICU? _____
If so, how long? _____

Oxygen needed: _____

Medications used during pregnancy: _____

Mother's pregnancy history: _____

Additional Birth information: _____

## Other Information

Does your child have any allergies? If yes, explain: _____

Does your child have any precautions? _____

Please list and explain relationships of members living in the same household with your child: _____

Does your child require any special equipment? If yes, explain: _____

Does your child have any problems with:
[] speech [] communication
[] vision [] hearing

Does your child favor holding his/her head in one position? If yes, how? _____

How long during the day does your child spend on his/her tummy? _____

Please describe any hobbies or activities that your child enjoys: _____

**Has your child had any surgeries or other hospitalizations?**

| Date | Surgery/Hospitalization | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

MOUNTAIN TOWN REHAB

**Has your child ever been diagnosed with the following conditions? Provide details please.**

YES NO Torticollis _____
YES NO Cerebral Palsy _____
YES NO Down Syndrome _____
YES NO Reflux _____
YES NO Juvenile Rheumatoid Arthritis _____
YES NO Heart Problems _____
YES NO Lung Disease _____
YES NO Stroke _____
YES NO Hearing disorder/loss _____
YES NO Muscle disease or disorder _____
YES NO Hydrocephalus _____
YES NO Asthma or reactive airway disease _____
YES NO Sensory Dysfunction _____
YES NO Diabetes _____
YES NO Cancer _____
YES NO Other _____
_____

**Please list any medications that your child is currently taking. (Prescription and over the counter medications. Include pills, vitamins, injections, patches, or via pump):** _____
_____
_____
_____

**Is your child currently receiving any other therapy? (physical, occupational, speech, chiropractic, school, etc.) If yes, explain what type, where, and how frequent:** _____
_____
_____
_____

**Have any of your child's immediate family members ever been told they have:**

| | | | |
|---|---|---|---|
| Cancer | YES NO | Who: | _____ |
| Diabetes | YES NO | Who: | _____ |
| High blood pressure | YES NO | Who: | _____ |
| Stroke | YES NO | Who: | _____ |
| Osteoarthritis | YES NO | Who: | _____ |
| Torticollis | YES NO | Who: | _____ |
| Rheumatoid Arthritis | YES NO | Who: | _____ |
| Genetic abnormalities | YES NO | Who: | _____ |
| | | What: | _____ |
| Other Diagnoses | YES NO | Who: | _____ |
| | | What: | _____ |

**Is there any other information not included on this form that may be helpful for the therapist to know about your child and his/her condition?** _____
_____
_____
_____