Physical address **106 E Victoria Court Ste. D ♦ Greenville, NC 27858-5708**
Mailing address **PO Box 3830 ♦ Greenville, NC 27836-1830**
Phone **252.321.6001**
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Email **therapeutic_innovations@yahoo.com**
Website **www.therapeutic-innovations.com**

Physical Therapy **Occupational Therapy** **Speech therapy**

Patient Information and Medical Health History

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

PATIENT INFORMATION				
Name *(Last, First, M.I.):*			**DOB:**	
Nickname:			**Age:**	**Gender:**
Address:_____ Street City State Zip Code				
Social Security Number:			**Home Phone:**	
Email address:			**Mobile Phone:**	
Primary or referring doctor:			**Alternate Phone:**	
FAMILY/SOCIAL HISTORY				
Patient Lives With: (Check all that apply)	☐ Birth Parents ☐ Adoptive Parents	☐ Foster Parents ☐ Stepparents	☐ Legal Guardian ☐ Siblings	☐ Extended Family ☐ Other
Please list siblings First names/Ages:				
Please list Parent/Guardian Names:				
Are there any court orders pertaining to custody of the patient, if so explain?				
Please list pet's names here:				
Preschool/Daycare:			**Contact Person:**	
Address:			**Phone Number:**	

Prenatal/Birth History			
Pregnancy Proceeded: ☐ Normally ☐ Had Complications		**Prenatal Care Was:** ☐ Received ☐ Not Received	
Delivery Proceeded: ☐ Normally ☐ Had Complications		**Delivery Was:** ☐ Vaginal ☐ C-Section ☐ Emergency C-Section	
Length of Pregnancy:		**Length of Child's Hospital Stay:**	
Child's Birth Weight: lbs. oz.	**Length:** in.	**Apgar Scores:** @ 1 min.	@ 5 min. @ 10 min.
List Pregnancy Complications:			

List Delivery Complications:		
Living Children:	**Number of Pregnancies:**	**Was this pregnancy a multiple birth?**
Were there any complications after birth, if so explain?		

Current Medications/Allergies

Please list current medications:
Please list any allergies:
Please list any vitamins, supplements, or homeopathic treatments:

Developmental History

The following questions are related to your child's development. Remember, every child develops differently than other children. The information we gather from these questions, will help us know your child better and assist us in meeting their therapy needs. Please do your best to answer each question in this section. If you have any questions, we will be happy to assist you, just ask.

Motor/Play

Please select all that describe your child:	☐ Active	☐ Cautious	☐ Distractible	☐ Insecure	☐ Stubborn	☐ Other:
	☐ Affectionate	☐ Curious	☐ Fearful	☐ Motivated	☐ Shy	
	☐ Aggressive	☐ Demanding	☐ Fearless	☐ Passive	☐ Stubborn	
	☐ Calm	☐ Difficult to comfort	☐ Fussy	☐ Persistent	☐ Withdrawn	

When did your child meet the following milestones:			Bring both hand to mouth	Grasping a toy	Hold up head alone
Sitting unassisted	Move to sitting unassisted	Creeping/crawling alone	Rolling over	Pull self, up to standing	Walking with support
Walking unaided	Self-Bathing	Self-Dressing	Button shirt/pants	Zipping/Unzipping Jacket	Tying shoes

Do you have concerns about handwriting? If so, what are your concerns?	
Does your child show preferred hand for writing?	**Which Hand?**
How does your child get around the house?	
Does your home have stairs?	
Does your child need to use these stairs to access their room or the bathroom?	
How do you access your home select all that apply: ☐ Stairs ☐ Ramp ☐ No stairs or ramp	

Sensory Processing/Regulation

Please select all that describe your child:	☐ Avoids getting messy	☐ Appears lethargic/sleepy all the time
	☐ Seeks out (craves) touch or movement	☐ Demonstrates stiff or rigid movement patterns
	☐ Stumbles or falls frequently	☐ Hyper-focused (on specific tasks, people, objects, etc.)
	☐ Appears awkward or less coordinated	☐ Uses a lot of pressure when touching someone or holding object
	☐ Flaps hands	☐ Has difficulty transitioning from one activity to another
	☐ Allows brushing of teeth	☐ Has poor sense of body in space, runs into things
	☐ Bangs on surface, bangs/hits head	☐ Resists certain movements (e.g. bouncing, swinging, upside down)
	☐ Fatigues quickly	☐ Seeks support for posture (E.g. leans on furniture, walls, or people, holds head)
	☐ Has self-abusive behaviors	☐ Has difficulty figuring out how to move body or takes more time with movements
	☐ Resists certain tasks or environments	
	☐ Spins things or self	
	☐ Is sensitive to lights, sounds or noise	
	☐ Sleeps a lot	
	☐ Resists touch	
	☐ Walks on toes	

	☐ Seeks out (craves) visually stimulating objects ☐ Seeks out (craves) stimulating sounds ☐ Has difficulty falling asleep ☐ Has difficulty remaining asleep through the night	☐ Does not tolerate certain textures (e.g. clothing, surfaces, foods, toys, etc.) ☐ Other:

Social/Emotional Skills

Please select all that describe your child:	☐ Is easily distracted ☐ Calms self easily ☐ Get angry/frustrated easily ☐ Is aggressive towards others ☐ Prone to emotional outbursts ☐ Prefers to play alone	☐ Has poor eye contact ☐ Has difficulty making friends ☐ Plays with peers ☐ Only plays with adults ☐ Has difficulty with separations	☐ Other:

Feeding

Please check all that currently apply to your child:	☐ Breast Feeding Times per day_____	☐ Bottle Feeding Times per day_____	☐ Solid Foods Times per day_____
Please list your child's preferred foods:			
Please list the foods your child dislikes:			
Please describe your child's eating habits:			

When did your child meet the following milestones:	Start Bottle	Stop Bottle	Start Breastfeeding
Stop Breastfeeding	Start Pacifier	Stop Pacifier	Start Baby Food
Start Junior food	Start Table Foods	Use Fingers to Self-Feed	Use Utensils
Use Straw	Hold Own Bottle/Cup	Start Sip Cup	Start Open Cup
Please select any areas of difficulty your child experiences:	☐ Chewing ☐ Swallowing ☐ Jaw shifts/slides/juts	☐ Transitioning Between foods ☐ Drooling ☐ Tongue movement	☐ Other:
Please select any feeding adaptations your child has:	☐ Thickened liquids ☐ Adapted Utensils	☐ Adapted Seating ☐ Calorie Supplements	☐ Tube Feeding ☐ None
Additional Feeding Concerns:			

Speech/Language

When did your child meet the following milestones:	Babble	Name Familiar Things	Use Short Sentences
	Say First Word	Put 2 words together	

Please select Yes or No to the following questions:	**YES**	**NO**
Does your child have speech that is understood by most people?		
Does your child respond correctly to yes/no questions?		
Does your child follow simple instructions?		

Does your child respond when name is called?				
Does your child stutter?				
Does your child recognize objects, people, and places?				
Please select the primary methods of verbal communication used by your child:	☐ None ☐ Vocalizations ☐ Single Words	☐ 2 Word Phrases ☐ Complete Sentences		
Please select the primary methods of non-verbal communication used by your child:	☐ Facial Expressions ☐ Body Language ☐ Manual Sign Language	☐ Gestures ☐ Pointing ☐ Eye Gaze		
Does your child use any form of Augmentative Communication, if so please explain?				
What is the primary language spoken in the home?				
How often does is your child exposed to English if the primary language spoken in the home is not English?				
Which language does your child use to communicate?				
Which language does your child understand better?				
Please list the date of your child's last hearing screening or test:				
Additional Communication Concerns:				

Additional Medical History

Please select Yes or No to the following questions:	**Child**		**Family Member** (Grandparent, Aunt/Uncle, Sibling, Parent)		
Has your child or an immediate family member ever, or are presently being treated for or diagnosed with:	**YES**	**NO**	**YES**	**NO**	**Who**
ADD or ADHD					
Allergies					
Arthritis					
Asperger's Syndrome					
Asthma/Other Respiratory Problems					
Autism					
Auto-Immune Disorders (Celiac, Lupus, IBD, etc.)					
Bleeding Disorder (any type)					
Brain/Spinal Injury					
Cancer/Chemotherapy					
Dental Problems					
Developmental Delay					
Diabetes					
Dizzy Spells/Fainting Spells/Loss of Consciousness					
Ear Infections and/or Ear Tubes					
Fracture					
GERD/Other Digestive Problems					
Headaches					
Head/Neck Trauma					
Heart Problems/Surgeries					

Please select Yes or No to the following questions:	**Child**		**Family Member** (Grandparent, Aunt/Uncle, Sibling, Parent)		
	YES	**NO**	**YES**	**NO**	**Who**
Hepatitis A					
Hepatitis B					
Hepatitis C					
HIV/AIDS					
Infections (MERSA, VRE, C-Diff)					
Metallurgy (implants)					
Pacemaker					
Seizures/ Epilepsy					
Sinus Problems					
Speech Delay					
Stroke					
Tuberculosis					

Please Explain any "Yes" answers here:

Do you now or have you had in the last 14 days any of the following symptoms? (please select all that apply)	☐ Productive Cough	☐ Appetite Loss	☐ Night Sweats
	☐ Coughing Blood	☐ Lethargy	☐ Fever
	☐ Weight Loss	☐ Lethargy	☐ Other:
Please select any of the equipment your child currently uses or has used in the past:	☐ Hand Splints	☐ Manual Wheelchair	☐ Track System
	☐ Elbow Splints	☐ Power Wheelchair	☐ Other:
	☐ Leg/Foot Braces	☐ Bath Chair	
	☐ Walker	☐ Hoyer Lift	
	☐ Stander	☐ Weighted Vest	

Please list any home programs you use with your child (e.g. stretching, strengthening, brushing, diet modifications, etc.):

Please list any community or extra-curricular activities in which our child participates:

Please select any of the following services or evaluations your child has received:	☐ Assistive Technology	☐ Nutrition	☐ IFSP (Individualized Family Support Plan)
	☐ Audiology	☐ Occupational Therapy	☐ Psychological Evaluation
	☐ Behavioral Therapy (ABA)	☐ Physical Therapy	☐ Neuropsychological Evaluation
	☐ Developmental Therapy	☐ Social Work	☐ Other:
	☐ Developmental Follow-up Clinic	☐ Speech/Language Therapy	
	☐ EI Services (Early Intervention)	☐ Vision Therapy	
	☐ Intensive Suit Therapy	☐ IEP (Individualized Education Program)	

Please use this space to share any additional concerns or to elaborate on any questions you feel need more information shared:

I believe the above to be true and correct to the best of my knowledge.

Responsible Party

Signature/Date:_____

May we have your permission to request information about previous medical, evaluations, and therapies related to your current concerns to assist us in or evaluation? If so, please fill out the attached "Authorization for Release of Information" form for each provider request.

Thank you for choosing Therapeutic Innovations to meet your therapy needs!!!

PATIENT INSURANCE INFORMATION	
Primary Insurance:	**Effective Date:**
Policy Number:	**Group Number:**
Policy Holder Name:	**Employer:**
Policy Holder Address:	
Secondary Insurance:	**Effective Date:**
Policy Number:	**Group Number:**
Policy Holder Name:	**Employer:**
Policy Holder Address:	
FINANCIAL RESPONIBILITY	
Name of Person Financially Responsible:	**DOB:**
Address:	
Home Phone:	**Mobile Phone:**

I believe the above to be true and correct to the best of my knowledge.

Responsible Party

Signature/Date:_____

FOR OFFICE USE ONLY		
Date of Review	Changes Yes/No	Clinic Manager