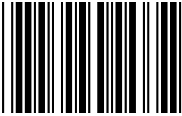
CHILDREN'S HEALTH



AIS
CMC77451-001NS **Rev. 4/2017**

Outpatient Therapy Services
New Patient Information

Today's Date:

BACKGROUND INFORMATION

Child's Name:	Date of Birth: / /	Gender: ☐ Male ☐ Female

Parent / Guardian(s) Name(s):	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Other: ______

Language(s) Spoken in the Home: ______ Interpreter needed: ☐ Yes ☐ No

Are there any religious / cultural practices we should know about that could better help us take care of your child: ☐ Yes ☐ No

If "Yes", please explain: ______

List of People Currently Living in the Household:

Name	Relationship to Child	Age

What is the main concern for your child's visit? ______

Referring Source: ______

Please list any other specialists that your child currently sees or is scheduled to see:

Physician ______ Phone Number ______
Physician ______ Phone Number ______
Physician ______ Phone Number ______
Physician ______ Phone Number ______
Physician ______ Phone Number ______

PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

Whom to contact: ☐ I do not wish Children's Health to disclose / discuss information to / with anyone.

I hereby give permission for Children's Health to disclose / discuss any information related to my child's therapy session(s) to / with the following family member(s), other relative(s) and / or close personal friend(s):

Name	Relationship	Phone	Okay to leave message with detailed information?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Whom to release child to: Same as listed above: ☐ Yes ☐ No

Your child will not be released to any person(s) whose name does not appear on this form. **NO verbal authorizations will be permitted.** Any additions or deletions MUST be submitted in writing. Children's Health Staff reserve the right to ask any individual to show proper identification. This is for the protection of your child.

I hereby give permission to Children's Health to release my child in my absence to any of the following people:

Name	Relationship	Phone	Okay to leave message with detailed information?
			☐ Yes ☐ No
			☐ Yes ☐ No

The duration of this authorization is infinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of any medical information.

Key: IgG = immunoglobulin G; IgE = immunoglobulin E; ICU = intensive care unit; GI = gastrointestinal

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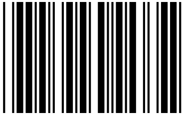

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COMMUNICABLE DISEASE / IMMUNIZATION SCREEN

Are your child's immunizations up-to-date? ☐ Yes ☐ No If "No", please contact your primary care physician.

In addition, we need for you to understand that the health and safety of all children and staff must be protected, so please be aware of the following:

________ *Initial Here* — **Your child may not visit or receive treatment if the child has any of the diseases / symptoms listed below.** May include but not limited to the following: Chicken pox, whooping cough, vomiting, uncontrolled diarrhea, strep throat, pink eye, head lice, scabies, or fever of greater than 100.5 degrees in the last 24 hours. If uncertain, please contact the clinic prior to your appointment.

________ *Initial Here* — **It is your responsibility to alert department, prior to your appointment, if your child is receiving treatment for infectious disease (Tuberculosis, C-Diff, Hand / Foot / Mouth, etc.). In order to determine if the patient is safe to keep scheduled appointment.**

________ *Initial Here* — **I am aware that these diseases could be harmful to children who receive treatment at Children's Health.**

MEDICAL HISTORY

Current Medications:
(please include all prescriptions, vitamins, supplements, appetite stimulants, over-the-counter medications, stool or emesis (vomit) controllers, and herbal or alternative remedies) (attach list if necessary)

Medication Name	Dose	Frequency

Allergies: ____

Allergy Test(s): (please include date of tests)

☐ Blood: ____ /____ /____ ☐ Skin patch: ____ /____ /____
☐ Skin prick: ____ /____ /____ ☐ Endoscopies: ____ /____ /____

Does your child have any medical conditions related to the following:

Heart	☐ No	☐ Yes	Bone /Joint injuries	☐ No	☐ Yes	Cancer	☐ No	☐ Yes
Lungs	☐ No	☐ Yes	Cytomegalovirus (CMV)	☐ No	☐ Yes	High blood pressure	☐ No	☐ Yes
Kidneys	☐ No	☐ Yes	Seizure	☐ No	☐ Yes	Difficulty eating	☐ No	☐ Yes
Digestive system	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes			
Surgery	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes			

Surgical History: Has your child had any surgeries? ☐ Yes ☐ No

Date	Surgery

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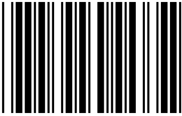

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Medical Procedures: (i.e. endoscopies, radiology testing, upper GI, swallow study, motility study, other GI tests, etc.)

Test	Date Tested	Outcomes
☐ Auditory Brain Stem Response		
☐ Electroencephalogram (EEG) - Brain		
☐ Vision assessment by Ophthalmologist		
☐ Hearing assessment		
☐ IgG or IgE allergy test		
☐ Food intolerance test (gluten, lactose, casein)		
☐ Magnetic Resonance Imaging (MRI)		
☐ Modified barium swallow study		
☐ Genetic screening		
☐ Other:		
☐ Other:		

Significant Illnesses or Hospitalizations:

Date	Illness / Reason for Hospitalization

Family History: ☐ Medical problems ☐ Psychiatric or psychological problems ☐ Developmental delay ☐ Feeding difficulty

Family Member	Relationship to Patient	Diagnosis

BIRTH INFORMATION

Baby was born: ☐ Full term ☐ Pre-term (Gestational age: ______) Birth Weight: ___________________

Type of delivery: ☐ Vaginal ☐ Cesarean section: ☐ planned ☐ emergency

Complications or problems noted? ☐ During pregnancy ☐ After birth ☐ None

Comments: ____

____

____

Did your child stay in Neonatal ICU? ☐ No ☐ Yes: Duration:________________

Comments / Reason for Stay: ____

____

____

Signature of Parent / Legal Guardian ____________________ Print Name ____________________ Date ____________ Time ____________

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