Date:____/____/_________

☐ **MALE** ☐ **FEMALE**

_______________________________ / / ___________________
PATIENT'S NAME (LAST, FIRST) **DATE OF BIRTH**

STREET ADDRESS **CITY** **STATE** **ZIP CODE**

HOME PHONE NUMBER **EMAIL ADDRESS FOR RECEIPTS**

/ /
FATHER'S/GUARDIAN'S NAME **DATE OF BIRTH** **CELL PHONE NUMBER** **SOCIAL SECURITY NUMBER**

EMPLOYER **POSITION** **PHONE NUMBER**

/ /
MOTHER'S/GUARDIAN'S NAME **DATE OF BIRTH** **CELL PHONE NUMBER** **SOCIAL SECURITY NUMBER**

EMPLOYER **POSITION** **PHONE NUMBER**

PRIMARY CARE PHYSICIAN **PHONE NUMBER** **REFERING PHYSICIAN** **PHONE NUMBER**

DO YOU HAVE A PERSCRIPTION? ☐ **YES** ☐ **NO**

Parent/Guardian Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other

Child lives with (check one): ☐ Birth Parents ☐ One Parent ☐ Parent and Step Parent
☐ Foster Parents ☐ Adoptive Parents ☐ Other________________

Child's race/ethnic group: ☐ Caucasian, Non-Hispanic ☐ African-American ☐ Hispanic
☐ Asian or Pacific Islander ☐ Native American ☐ Other________________

Is there a language other than English spoken in the home? ☐ Yes ☐ No If yes, which one?___________________

How did you hear about us?____

Insurance Information

*Primary Insurance Name:*______________________________ Phone# __________________________________

ID#:______________________________ Group#_______________________ Effective Date:_______________________

Subscriber's Name*:*____

*Secondary Insurance Name:*______________________________ Phone# __________________________________

ID#:______________________________ Group#_______________________ Effective Date:_______________________

Subscriber's Name:____

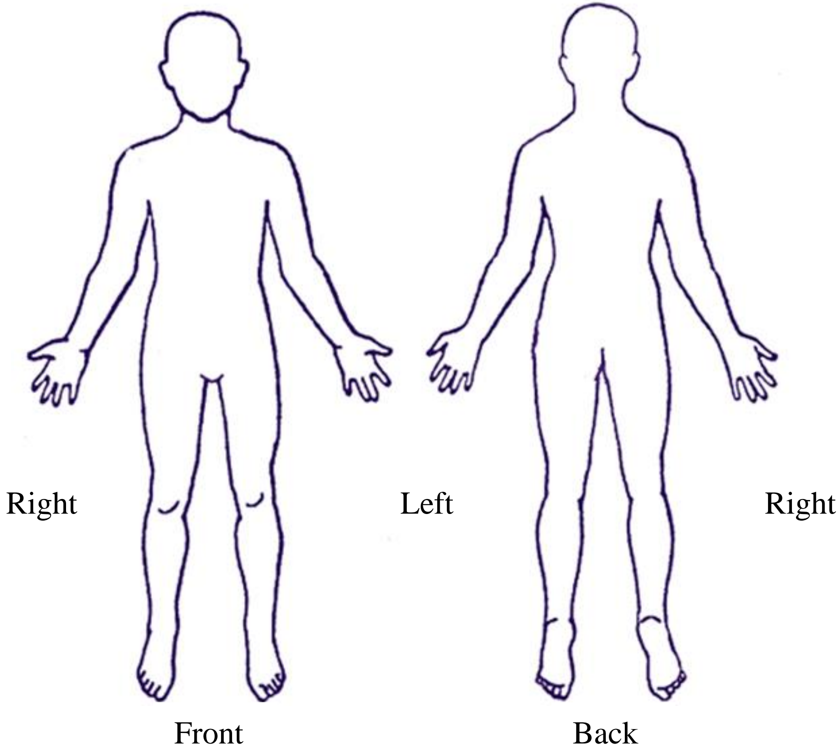
PATIENT'S NAME: ______________________________ **DATE OF BIRTH:** ________________________

What is your chief complaint? ____

____

____

Please mark the location of your pain on the figures below.



How would you describe your pain?
Check all that apply:

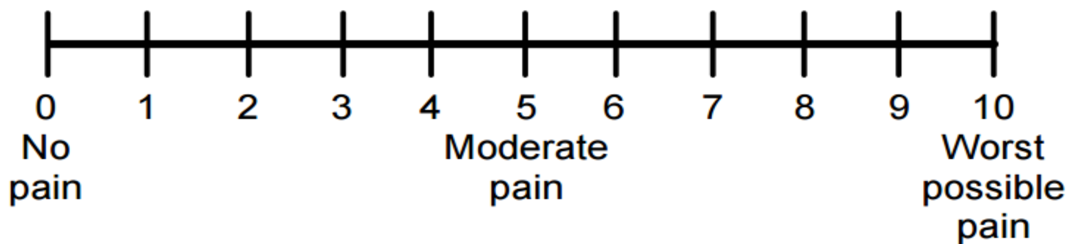
- ☐ Sharp
- ☐ Aching
- ☐ Dull
- ☐ Shooting
- ☐ Cramping
- ☐ Throbbing
- ☐ Stiffness
- ☐ Burning
- ☐ Radiating
- ☐ Tingling
- ☐ Numb

How does your pain change over time?

- ☐ Continuous
- ☐ Frequent
- ☐ Occasionally
- ☐ Intermittent

On the numerical scale below, rate your pain:

- Pain at WORST: __________________
- Pain at BEST: ____________________
- Pain TODAY: _____________________



What makes your pain worse? ____

____

What makes your pain better? ____

____

PATIENT'S NAME: ______________________________ **DATE OF BIRTH:** ___________________________

Date of injury or when the pain began: ____

How did the problem begin? (Injury, fall, motor vehicle accident, sports, etc.) ______________________

____

Have you had any diagnostic tests for this problem? (X-ray, MRI, CT scan, etc.) _____________________

____

Which activities are more difficult since this problem began? Check all that apply:

☐ Personal care	☐ Walking	☐ Getting in/out of bed
☐ Exercising	☐ Standing	☐ Sleeping
☐ Driving	☐ Sitting	☐ Concentrating
☐ Recreational activities / sports / gym class	☐ Bending	☐ Working / chores
	☐ Lifting	☐ Other

What types of activities / hobbies / exercises do you regularly perform and how often? ________________

____

____

List any surgeries and dates: ____

____

Do you have any other pertinent medical history or diagnoses? ___________________________________

____

Please list any medications your child (please include purpose of the medication)? ____________________

____

____

Does your child have any known allergies to food or to the environment? ☐ ↑ ☐Yes ↑No

If yes, please list____

What are your goals for therapy? ____

____

PATIENT'S NAME:________________________________ DATE OF BIRTH:_____________________

PHOTO PERSMISSION

	Initial
1. I give permission for photographs/videotape of my child for the purpose of treatment, education, and documentation.	______
2. I give permission for photographs/videotape of my child for website/Facebook.	______

Notice of Privacy Practices (HIPPA Acknowledgement/Consent)

I hereby acknowledge receipt of the Notice of Privacy Practices for ABC Pediatric Therapy, LLC. I hereby consent to the use and disclosure of my child's protected health information (PHI) for the purpose of evaluation, treatment, payment, and health care coordination.

Initial:_________

Thank you for your time in filling out this information regarding your child.

Completed by: __________________________ Relationship: ____________________ Date:__________