



## Patient Face Sheet

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: Home: \_\_\_\_\_

Mom Cell# \_\_\_\_\_ Dad Cell# \_\_\_\_\_

Mom Work# \_\_\_\_\_ Dad Work# \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Would you like to be included in our Parent Connection to receive information about upcoming events, hot topics, and activities: Y or N

Emergency Contact: Name: \_\_\_\_\_

Phone# \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_ Diet Restrictions \_\_\_\_\_

Sensory Aversion/Triggers: \_\_\_\_\_ History of Seizures: Y or N

Does your child receive any other services: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Physician Phone #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Referred By: \_\_\_\_\_

**I confirm that all of the above information is accurate, and I agree to notify K.I.D.S. Therapy Associates, Inc. of any changes.**

\_\_\_\_\_  
Parent or Guardian Signature

Date: \_\_\_\_\_

**Office use only** ICD-9 Code(s): \_\_\_\_\_



Please fill out completely  
as it is very important in order to  
ensure a great treatment plan.

### Developmental Questionnaire

Today's Date \_\_\_\_\_

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Person completing this form: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Child's Primary Care Physician: \_\_\_\_\_ Referred by: \_\_\_\_\_

**STATEMENT OF THE PROBLEM**

Describe as completely as possible the reason for referral / concern: \_\_\_\_\_

When was the problem first noticed? \_\_\_\_\_

What do you feel are some reasons for this problem? \_\_\_\_\_

Has your child received help for this problem? If so, what type? \_\_\_\_\_

Where? \_\_\_\_\_ When? \_\_\_\_\_

What would you like to accomplish through this assessment process? \_\_\_\_\_

Has the child ever been diagnosed with:

<input checked="" type="checkbox"/>		BY WHOM	WHEN	DO YOU AGREE?	
				Yes	No
	Autism				
	Cerebral Palsy				
	Developmental Syndrome				
	Fine Motor Problem				
	Gross Motor Problem				
	Head Injury				
	Hearing Loss				
	Learning Problem				
	Mental Retardation				
	Neurological Problem				
	Speech and or Language Problem				
	Visual Impairment				
	Other (specify)				

Mark any evaluations or therapy received. If received by the child, mark a "C"; if received by another family member, mark an "F".

\_\_\_\_\_Speech-Language      \_\_\_\_\_Occupational      \_\_\_\_\_Behavioral      \_\_\_\_\_Psychological

Physical                       Hearing                       Counseling                       Nutritional  
 Parent Training                       Educational                       Developmental

Describe results: \_\_\_\_\_

---

**PREGNANCY AND BIRTH HISTORY**

Were there any complications, illnesses, accidents, or stress-producing events during pregnancy?     Yes     No

If yes, please explain: \_\_\_\_\_

Was the baby born prematurely?     Yes     No    How many weeks early? \_\_\_\_\_

Where was the baby born? \_\_\_\_\_ How long was the infant in the hospital? (days/months) \_\_\_\_\_

Birth Weight: \_\_\_\_\_ APGAR Scores: \_\_\_\_\_

Were there any unusual problems at birth?     Breathing difficulty     Feeding difficulties

Explain: \_\_\_\_\_

---

**MEDICAL HISTORY**

Is the child now under the care of a doctor(s)?     Yes     No    Who? \_\_\_\_\_ Why? \_\_\_\_\_

Are immunizations up-to-date?     Yes     No

Is the child in pain?     Yes     No    If yes, please explain: \_\_\_\_\_

Is the child taking medication?     Yes     No    Type(s)? \_\_\_\_\_ Why? \_\_\_\_\_

Is the child taking herbs?     Yes     No    Type(s)? \_\_\_\_\_ Why? \_\_\_\_\_

Do you think hearing is normal?     Yes     No

Has child's hearing ever been tested?     Yes     No    If so, when? \_\_\_\_\_

Where? \_\_\_\_\_ Results? \_\_\_\_\_

Do you think your child's vision is normal?     Yes     No    Does your child wear glasses?     Yes     No

Has child's vision ever been tested?     Yes     No    If so, when? \_\_\_\_\_

Where? \_\_\_\_\_ Results? \_\_\_\_\_

Has your child experienced any of the following?

	AGE	EXPLAIN		AGE	EXPLAIN
Adenoidectomy			Eye Problems		
Allergies			Heart Problems		
Asthma			High Fevers		
Blood Disease			Meningitis		
Chronic Colds			Muscle Disorder		
Dental Problems			Nerve Disorder		
Diabetes			Seizures		
Ear Infections			Tonsillectomy		
Encephalitis			Other		

**DEVELOPMENTAL HISTORY**

At what age did the following occur?

Held head up:	Rolled over:	Sat alone unsupported:	Crawled:	Walked Alone:
Weaned from bottle:	Said first words:	Put words together:	Was toilet trained:	Followed simple directions:

**Family History**

Parents' ages at birth of child: Father \_\_\_\_\_ Mother \_\_\_\_\_ Highest grade level attended: Father \_\_\_\_\_ Mother \_\_\_\_\_

Father occupation: \_\_\_\_\_ Mother occupation: \_\_\_\_\_

Please list siblings:

NAME	SEX	DATE OF BIRTH

Have any relatives (including parents, grandparents, siblings, aunts, uncles, cousins) had any of the following?

	YES	NO	IF YES, WHO?
Autism			
Developmental problem			
Drug or alcohol problems			
Hearing problems			
Hyperactivity			
Learning problems			
Mental retardation			
Psychological problems			
Seizures or epilepsy			
Severe behavior problems			
Speech problems			

Have there been any recent significant stress-producing events?  Yes  No For whom?  Parent  Child

If yes explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Feeding:**

Check these as they applied / apply to your child:

	Yes	No	Explain (give age)
Difficulty sucking			
Difficulty chewing			
Difficulty swallowing			
Picky eater			
Prefers soft foods			
Excessive drooling			
Food comes out nose			

**Language/ Communication:**

What is the primary language spoken in the home: \_\_\_\_\_

What other language is the child exposed to: \_\_\_\_\_ Where: \_\_\_\_\_ How often: \_\_\_\_\_

How does your child communicate his/her needs: \_\_\_\_\_

How much of the child’s speech do you understand?  0%  10%  25%  50%  75%  100%  Too young to talk

Does your child respond when you call his/her name?  Yes  No

Is your child able to follow simple direction such as come here, sit down, stop?  Yes  No

Is your child able to follow multiple step directions?  Yes  No

Does your child use words/phrases to:

Make Requests:  Yes  No

Comment:  Yes  No

Protest:  Yes  No

Answer questions:  Yes  No

Ask questions:  Yes  No

**Play/Behavior:**

Please answer yes/no about the following behaviors:

	Yes	No	Explain:
Is your child able to separate from parent/caregivers:			
Notice when you leave the room/house:			
Easy to discipline:			
Make eye contact with others:			
Play social games (peek-a-boo paddy cake):			
Show interest in other children:			
Initiate interaction with other children:			
Play with objects and/or toys appropriately:			

	Yes	No	Explain:
Play with other children appropriately:			
Imitate actions in play of other children or adults:			
Is your child able to share toys with other children or adults:			
Is your child able to take turns in activities/games:			
Know when you are upset with him/her:			

What are your child's favorite toy/ activity? \_\_\_\_\_

Does your child exhibit any of the following behaviors?

- |   |   |
|---|---|
| <input type="checkbox"/> Aggressiveness       | <input type="checkbox"/> Lives in own world |
| <input type="checkbox"/> Biting               | <input type="checkbox"/> Hitting            |
| <input type="checkbox"/> Injures self         | <input type="checkbox"/> Tantrums           |
| <input type="checkbox"/> Repetitive Behaviors | <input type="checkbox"/> Rocking            |

Describe any other behavior that is a problem to the parents: \_\_\_\_\_

How do you manage the behavior(s)? \_\_\_\_\_

**Sensory Processing:**

Please answer the following statements:

	Almost Always	Occ.	Rarely	N/A
Does your child have irregular sleep patterns?				
Does your child seem generally weak/ floppy when held?				
Does your child seem clumsy or uncoordinated?				
Does the feel of certain clothing irritate your child?(Shirt, pants, socks, shoes)				
Does your child resist being held?				
Does your child avoid messy play activities such as finger painting, sand, glue etc.?				
Does your child seem excessively fearful of movement? (e.g. going up or down stairs, swings, slides, other playground activities)				
Does your child seek out all kinds of movements that interfere with his/her daily routines?				
Does your child startle or become distressed by loud or unexpected sounds?				
Is your child bothered by and have a difficulty concentrating with loud background noise such as construction work or machinery?				
Does your child appear not to hear certain sounds?				
Is your child sensitive to or bothered by light (squint, cries, closes eyes etc.)?				



Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Authorization for Use or Disclosure of Health Information**

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization.

**USE AND DISCLOSURE OF INFORMATION**

Patient's Name \_\_\_\_\_  
Last, First, Middle Initial \_\_\_\_\_ Date of Birth \_\_\_\_\_

I, the undersigned, do hereby authorize K.I.D.S. Therapy Associates, Inc., San Diego, CA, to provide health information from the above-named patient's medical record to:

\_\_\_\_\_  
Name and function of person or organization to which disclosure is made

\_\_\_\_\_  
Address \_\_\_\_\_ City And State \_\_\_\_\_ Zip Code \_\_\_\_\_

This disclosure of health information is required for the following purpose:

\_\_\_\_\_

Dates of Service: \_\_\_\_\_ Requested information shall be limited to the following:

\_\_\_\_\_

**EXPIRATION**

This Authorization expires [insert date or event]: \_\_\_\_\_

**RESTRICTIONS**

California law prohibits the requestor from making further disclosure of my health information unless the Requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

**YOUR RIGHTS**

I understand that I have the following rights with respect to this Authorization:

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to: K.I.D.S. Therapy Associates, Inc., 11838 Bernardo Plaza Court, Suite 110 San Diego, CA, 92128. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I have a right to receive a copy of this Authorization. I may not be required to sign this Authorization as a condition to obtaining treatment.

**APPROVAL**

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

\_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Area Code and Phone Number \_\_\_\_\_ Date info sent by (Name) \_\_\_\_\_

# Directions to K.I.D.S. Therapy Associates, Inc.

11838 Bernardo Plaza Court, Suite 110  
San Diego, CA 92128 858-673-5437

Directions: From 15 N exit Rancho Bernardo Road and turn right. At the next light, turn right onto Bernardo Center Drive. At the 2<sup>nd</sup> stoplight (the first light is for the fire station), turn right onto Bernardo Plaza Court. Shortly after you make the turn, our building is on the right hand side of the road. Turn into the second driveway at Citi Bank and drive towards the back of the parking lot. We are in Suite 110 (the second building located behind Citi Bank).

Directions: From 15 S exit Rancho Bernardo Road and turn left and go under the freeway. At the next light, turn right onto Bernardo Center Drive. At the 2<sup>nd</sup> stoplight (the first light is for the fire station), turn right onto Bernardo Plaza Court. Shortly after you make the turn, our building is on the right hand side of the road. Turn into the second driveway at Citi Bank and drive towards the back of the parking lot. We are in Suite 110 (the second building located behind Citi Bank).