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.

____ **Date:** ________________

Parent or Guardian Signature

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:

☑		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?

☐ Aggressiveness ☐ Lives in own world

☐ Biting ☐ Hitting

☐ Injures self ☐ Tantrums

☐ Repetitive Behaviors ☐ 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 2nd 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 2nd 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).