

When Completed Please Return This Form To:  
6855 W Fairview Ave Ste 120, Boise ID 83704  
(208) 323-8888

Date:

### Parent Questionnaire

_____			Today's Date
Name of child	_____		Birth date
_____			
Child lives with	_____		Relationship
_____			
Address	City	Zip code	
_____			
Telephone home	work	other	
_____			
Marital status of parents			
_____			
Mother's name	_____		Father's name
_____			
How did you find our about our services			
_____			
Reason you are seeking help			
_____			
_____			
Primary language spoken in the home		Primary language spoken by the child	
_____			
Your child's physician		Other medical specialists	
_____			

### Prenatal and Birth History

Was there anything unusual about your pregnancy with this child? (i.e. illness, accident, medications, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Complications at birth: (check any that apply)

\_\_\_\_trouble breathing      \_\_\_\_jaundice      \_\_\_\_blue color  
\_\_\_\_birth injuries      \_\_\_\_irregular heart rate      \_\_\_\_other

Please explain any areas checked

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Circle type of delivery:      head first      feet first      breech      caesarian  
Full term: \_\_\_\_\_      Premature: \_\_\_\_\_  
Baby's weight at birth: \_\_\_\_\_ lbs, \_\_\_\_\_ oz.      natural \_\_\_\_\_      c-section \_\_\_\_\_

Place of birth: \_\_\_\_\_      How long did your child remain hospitalized after birth

Please describe any illness or medical problems your child has had:

\_\_\_\_\_

\_\_\_\_\_

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Do you notice, or has a doctor reported diagnosed (Please check).

asthma       frequent fevers       nightmares       seizures       sinus trouble  
 heart trouble       allergies       cerebral palsy       draining ear       ear infections  
 mastoiditis       frequent colds       tonsillitis

Has your child ever been hospitalized? (explain)

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Had a serious accident?

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Had an operation? (including tubes in ears, adenoidectomy, etc.):

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Is your child currently taking medication?

Describe type(s) and reason

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Any negative reactions to medication? \_\_\_\_ If yes, please identify

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Do any relatives have any of the characteristics listed below:

emotional illness       retardation       hereditary diseases       epilepsy  
 cerebral palsy       learning disability       hearing impaired       vision impaired  
 speech disability       cleft lip/palate      \_\_\_\_\_ other

Has your child ever had an ear/hearing examination or treatment?

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When

Where

Results

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Has your child ever had a history of ear infections?

How often?

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What treatment?

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Has your child ever had a vision examination or treatment?

When?

Where?

Results?

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Does your child wear glasses?

Have eyes that turn in?

Have eyes that turn out?

### **Developmental Milestones**

Provide the approximate age at which your child began to do the following activities:

crawl       feed self       use toilet       sit unassisted       dress self       stand  
 walk      \_\_\_\_\_ use single words (i.e. no, mama, doggie, etc.)  
 combine words (i.e. me go, daddy shoe, etc.)      \_\_\_\_\_ name single objects (i.e. dog, car, spoon, etc.)  
 use simple question (i.e. Where's doggie?)      \_\_\_\_\_ engage in conversation

### **Speech/Language**

Have you noticed any speech problems? Please describe your child's speech in your own words

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Do other people have difficulty understanding your child's speech Please explain.

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Does your child appear to have difficulty understanding what you say or following directions? Please explain.

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Does your child rely on gestures to make needs known? Please explain.

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Do you think your child's speech has changed in the past six months? Please explain.

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Has the family made any effort to correct the child's speech problem? How?

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### **Behavior/Social Developmental**

During the child's have there been changes in the family situation (such as change in parent's marital status, frequent, frequent move, death, etc.) Please describe.

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How does your child get along with other children?

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Do you have any problems managing your child's behavior?

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Does your child have any sleeping problems? Explain.

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What kind of things does your child do that bother you?

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Does your child have any special fears (dogs, darkness, etc.)?

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Are there things your child does that you think are unusual?

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Does anyone read stories to this child?

Who?

How often?

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What TV show does this child watch?

How many hours per day?

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Has this child ever been to a nursery, day care or preschool center? Please list in order of attendance and indicate length of time.

- 1.
- 2.
- 3.
- 4.
- 5.

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**General Information**

How do you view your child's development as compared to other children of the same age?

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What are your concerns about your child?

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Is there anything that you would like to learn more about that would help you and your child?

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Please describe three or four things about your child that you consider to be strengths (things your child does well, personality traits, etc.)

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Is there any additional information that you feel is important in order to better understand your child?

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## Children's Therapy Place Inc.

*New Patient Consent to the Use and Disclosure of Health Information for Treatment, payment or operations.*

I, \_\_\_\_\_, the parent/guardian of \_\_\_\_\_ understand that as part of my child's services, PTS/CTP originates and maintains paper and/or electronic records describing my child's service history. I understand that this information serves as:

- ❖ A basis for evaluation and therapy treatment,
- ❖ A means of communication among the many health professionals who contribute to my care,
- ❖ A tool for assessing quality and reviewing the competence of therapists.

I am aware that PTS/CTP has a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I may request a copy of the Notice if I so desire. I also understand that I have the following rights and privileges:

- ❖ The right to review of the notice prior to signing this consent,
- ❖ The right to object to the use of my child's information for directory purposes, and
- ❖ The right to request restrictions as to how my child's information may be used or disclosed to carry out treatment, payment, or therapy operations.

I understand that PTS/CTP is required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that PTS/CTP reserves the right to change its notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. I may request a revised Notice of Privacy Practices at any time by calling the office and requesting a copy or by asking for a copy at my next visit.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

\_\_\_\_\_

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Parent/Guardian's Signature

Date:

Date

## ***Client Information/Guarantee of Payment***

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cellular Phone \_\_\_\_\_

### **Emergency Contacts** (if parent/guardian can't be reached)

Name \_\_\_\_\_ Phone 1 \_\_\_\_\_

Relationship \_\_\_\_\_ Phone 2 \_\_\_\_\_

### **Parent/Guardian Authorization:**

I \_\_\_\_\_, Parent/Guardian of \_\_\_\_\_, give permission for my child to receive an evaluation and/or therapy services provided by Children's Therapy Place, Inc. In addition, I agree to pay for services provided by Children's Therapy Place, Inc. Payment for services are due at time of visit, unless other arrangements have been made. Receipts will be generated through our billing office, and mailed to clients to submit to their respective insurances.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

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**INSURANCE INFORMATION AND AUTHORIZATION FOR PAYMENT**

Insured's Name \_\_\_\_\_  
Name of Insurance \_\_\_\_\_  
Insurance ID Number \_\_\_\_\_  
Insured's Date of Birth \_\_\_\_\_  
Insured's Policy Group or FECA Number \_\_\_\_\_  
Employer's Name or School Name \_\_\_\_\_  
Insurance Plan Name or Program Name \_\_\_\_\_

**\*\* Please submit a copy of your insurance card\*\***

Is there another health benefit plan? \_\_\_\_ Yes \_\_\_\_ No  
Secondary Plan of Insurance \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Name of Insurance \_\_\_\_\_  
Insurance ID Number \_\_\_\_\_  
Insured's Date of Birth \_\_\_\_\_  
Insured's Policy Group or FECA Number \_\_\_\_\_  
Employer's Name or School Name \_\_\_\_\_  
Insurance Plan Name or Program Name \_\_\_\_\_

**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:** I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

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

**INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:** I authorize payment of medical benefits to Children's Therapy Place for therapy services received.

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