Children's Therapy Group, Inc.
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CLIENT ENROLLMENT & HISTORY

Fill in the questionnaire as completely as possible. If a section does not apply, put N/A. Return the completed form to the office or evaluating/treating therapist.

Person completing this questionnaire (i.e., mother, father, guardian, etc.) _____
Signature of person completing this form_____ Date _____

1. Child's Name: _____ Home Phone: ( )_____
   Address:_____
   City: _____ State:_____ Zip Code: _____
   Birthdate:_____ Age: _____ Sex: _____
   Is child adopted? _____ If yes, from what country?_____
   If yes, at what age? _____ Foster child?_____ If yes, at what age?_____

2. Mother's Name: _____ Home Phone: ( )_____
   Cell Phone: ( )_____ Work Phone: ( )_____
   Address (if different from Child's):_____
   Education: _____ Occupation: _____ Email address: _____

3. Father's Name: _____ Home Phone: ( )_____
   Cell Phone: ( )_____ Work Phone: ( )_____
   Address (if different from Mother's):_____
   Education: _____ Occupation: _____ Email address: _____

4. Marital status (Please check): Married_____ Separated _____ Single_____
   Divorced _____ Widowed _____ Living Together _____

5. With whom does child reside? Mother ___ Father ___ Both ___ Guardian, specify _____

6. Referred by: _____ Relationship/connection to your child:_____

Emergency Contact / Treatment: *Should a child be injured or become ill, Children's Therapy Group (CTG) will attempt to locate parent(s). If parent(s) cannot be located, parent(s) agrees that CTG may use its own judgment in deciding whether to seek emergency medical treatment for child at the closest hospital emergency room, and that CTG will not be held liable for any emergency treatment sought, rendered or refused, or for any consequence of such treatment or refusal to treat.*

Name of emergency contact:_____ Relationship to child:_____
Home Phone: ( ) _____ Cell / Work Phone: ( ) _____

Doctor:_____ Phone: ( ) _____
Address, City, State, Zip: _____

Allergies:_____

Parent's Signature _____ Date_____

Financial Agreement

If therapy is a service covered by your insurance company, do you wish to have CTG file for you?
Yes _____ (If yes, ask for and complete Insurance Information form.) No _____

You will receive a bill each month for services occurring in the previous 30 (31) days. **Payment is due by the 15th of each month**. As a not-for-profit, CTG relies on parents paying their bills promptly. The enrolling parent will automatically be considered responsible for payment of services unless other arrangements have been made in advance. If you want us to file insurance for you, please make arrangements with the Administrative Assistant in our office. **However, parents will be responsible for paying each month, their portion of charges that the insurance company does not pay.** If monthly payments are not received on an account, therapy services may be suspended. ***Should your account be sent to our collection agency for any reason, any or all of your information can be turned over to the collection agency.***

I have read the above Financial Agreement and agree to the policies stated in it.

Parent's Signature _____ Date_____

Consent:

1. I give my consent for evaluation and/or treatment to be conducted by CTG staff as indicated according to acceptable standards of practice. I have read and understand the Notice of Privacy Practices (NPP), Policies and Procedures, Non-Discrimination Policy, and Payment Options Statements.

   Parent's Signature_____ Date_____

2. I give my consent for photographs to be taken of therapy for use in education of other parents and professionals. (Optional)

   Parent's Signature_____ Date_____

Consent for Mailing List:

By including you on our mailing list (email and U.S mail), we can provide you with information regarding our summer programs, special events, and services. Our mailing list is never sold or provided to any other agency or business. Do you want to be included on our mailing list? Yes ___ No ___
If nothing is marked, it is assumed you are giving consent to add your information to our list(s).

Records Release Authorization: You may request copies of your reports to give to your medical doctor, school or other professional.

CHILDREN'S THERAPY GROUP NOTICE OF PRIVACY PRACTICES (NPP)

We understand that medical information about you and your health is personal. We are committed to protecting your medical information.

Under the Federal HIPAA / HITECH Act Omnibus Rule, we are required to inform you of our guidelines regarding privacy of medical information/personal health information (PHI).

CTG requires all Patients (Parent if minor) to give written prior authorization for each agency/person or anything not explicitly described in our document before CTG will release PHI. Separate authorization (written or verbal) will be obtained for non-routine disclosures. These authorizations expire one year from date of signature. To revoke the authorization you will need to provide a written request to Children's Therapy Group. Without such permission, information will not be released. Permitted disclosures include:

- The staff (paid and nonpaid) and therapy students of Children's Therapy Group has agreed, as permitted by law, to share your PHI among themselves for purposes of your treatment, payment, or health care operations. This enables us to better address your health care needs.
- A medical emergency
- An involved third party (e.g., a divorced spouse)
- In the event of nonpayment
- Legal action (e.g., subpoena)
- Public health needs
- Activities related to national defense and security
- Insurance companies: Note, in most cases, you agreed upon accepting/purchasing health insurance coverage to allow your insurance company access to your child's current and pertinent previous medical information. Your signature on our enrollment and insurance information forms permits us to release information as needed for the filing and processing of medical claims.

While the original medical record is the property of Children's Therapy Group, Patients (Parent if minor) have the right to copies of their records or to view them at any time. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. Patient records are kept for ten years from their date of discharge. Patients (Parent if minor) have the right to request restrictions (in writing) on the uses and disclosures of their information at any time.

Patients (Parent if minor) have the right to restrict certain disclosures (in writing) of PHI to a health plan if the individual has paid out-of-pocket in full for the health care service(s).

We will not disclose information regarding scheduled appointments, such as the date/time of your child's appointments, or even acknowledge to others that your child is a patient in this practice without your consent.

Our staff (paid and nonpaid) have access to your child's PHI which is necessary for the performance of his/her job. All employees, therapy students, volunteers, and business associates who may have access to your child's and family's personal information sign a confidentiality statement to protect your personal information.

Children's Therapy Group does not sell PHI. If any client information is needed for marketing or fundraising purposes, Children's Therapy Group will request written permission from the Patient (Parent if minor). All Patients (Parent if minor) are given the opportunity to opt out (in writing) of our fundraising/mailing lists.

We reserve the right to change this notice at any time. We reserve the right to make the revised notice effective for information we already have as well as any we receive in the future.

PRIVACY PROTECTION:

CTG will notify any Patient (Parent if minor) of any security breach that compromises the privacy of their PHI. CTG cannot guarantee the security of any PHI transmitted electronically.

The Patient (Parent if minor) has the right to file a formal complaint with CTG or their health plan, or with Health and Human Services (see the address below), about violations of the provisions of this rule (HIPAA) or the policies and procedures of the covered entity.

Department of Health & Human Services, Office for Civil Rights
601 East 12th Street, Room 248, Kansas City, MO 64106
Phone #: 816-426-7278 Fax #: 816-426-3686

_____ _____

Signature Date

_____

Please Print Name Relationship to Patient/Client

HISTORY

1. What are your primary concerns about your child? _____

_____

What are the school's primary concerns? _____

_____

Did either parent experience similar problems as a child? _____

_____

2. Has your child been diagnosed as having any medical or educational condition? _____

If so, what? _____

Who made the diagnosis and when was it made? _____

_____

Other evaluations, past programs or therapy? _____

3. Check which of the following specialists your child has seen/is seeing:

Specialty	Name of Agency/Specialist	Date	Address	Phone
Cardiologist				
Orthopedist				
Neurologist				
Psychologist/ Psychiatrist				
Ophthalmologist/ Optometrist				
ITS Case Manager				
Early Childhood Special Educator				
Speech Pathologist				
Occupational Therapist				
Physical Therapist				
Audiologist				
Chiropractor				
ENT				
Other				

FAMILY HISTORY

1. Names of brothers/sisters Age Sex Grade in School

_____

_____

_____

Do these brothers/sisters live with the child? _____

2. Names of others living in the home (Parents, Uncles, Aunts, Grandparents, etc.):

Name_____Relationship_____Age_____

Name_____Relationship_____Age_____

Name_____Relationship_____Age_____

3. With whom does the child spend most of his/her day? _____

Names of other closely involved with child:_____

4. How does your child choose to use his/her free time? _____

_____

Does your child play appropriately with toys? (e.g., uses a toy truck as intended) yes___ no___
Does your child exhibit appropriate pretend & imaginary play? (e.g., plays house, imaginary play with figurines, etc.) yes ___ no ___

If no to either question, explain_____

5. Who is generally responsible for discipline and rule setting at home? _____

What methods are used and what seems most effective? _____

_____

How does the child react to discipline? _____

Does the child tantrum? _____ Have you observed any head banging or self-destructive behavior? _____If yes, explain_____

_____

6. Are there any speech, physical or learning problems among family members, relatives?

Name	Relationship	Describe Problem

7. Has your family experienced any recent crisis or major change (stress) that you feel is important to your child's development (financial problems, moves, job changes, divorce/separation, death, etc.)? If so, explain_____

_____

MEDICAL HISTORY

1. Pregnancy: Full term_____ Premature_____ (born at how many weeks gestation?)

   Mother's general health during pregnancy: Good_____ Fair_____ Poor_____.
   Problems encountered during pregnancy (illness, injuries, stress, bleeding, fainting spells, anemia, etc.)_____

   Medications taken during pregnancy (please specify)_____

   _____

2. Labor: Length of total labor _____ Hard labor _____ Problems encountered during labor_____

3. Delivery: Type _____ Anesthesia _____ None _____
   Pudendal _____ Cervical Block_____ Other_____

   Complications - Induced birth_____ Breech presentation_____
   Cesarean section_____Forceps delivery_____ Elaborate on above delivery complications and note any others not included:_____

4. Birth: Child's birth weight _____ lbs. _____ oz.

   Complications: Jaundice_____Cyanosis_____ Congenital defects_____ Limpness_____
   Stiffness_____ Elaborate on above complications at birth and note any other not included:

   _____

Was there a need for? oxygen____ transfusions____ tube feedings____ If so, please explain

_____

Were there any feeding difficulties at birth or now? Yes_____ No_____. If yes, explain_____

_____

Length of hospitalization_____

Problems encountered during child's first month_____

_____

5. List illnesses/diseases child has had (other than the usual):

   Illness_____ Age at that time_____

6. List injuries/operations child has had:

   Injury/operation_____ age_____

   Injury/operation_____ age_____

7. Has child had high fevers? age_____ temp._____ frequency_____
   Has child had convulsions/seizures? age_____ type_____
   frequency_____medication_____

8. Child's general health at present: good_____ fair_____ poor_____

   Any present medications? yes_____ no_____ If yes, type_____
   For_____ Any physical handicaps? yes_____ no_____
   If yes, describe_____

   Any ear infections? yes_____ no_____ If yes, frequency_____
   Tubes? yes_____ no_____ when_____

   Any draining ears? yes_____ no_____ If yes, how were these treated_____

   Has your child been diagnosed with a hearing loss? yes _____ no _____
   Right ear _____ Left ear _____ Does he/she wear hearing aid(s)? yes ____ no ____
   Who diagnosed the hearing loss _____

9. Has your child ever been exposed to lead or lived in an older (prior to 1970) home?
   yes_____ no_____

DEVELOPMENTAL HISTORY

1. Check which of the following describes your child as an infant:

___ Fussy, irritable
___ Quiet
___ Active
___ Resisted being held
___ Tense muscles when being held
___ Irregular sleep patterns
___ Had colic
___ Good, non demanding
___ Passive
___ Liked being held
___ Floppy when held
___ Good sleep patterns
___ Over active, never still unless sleeping

Comments:

2. Check which describes your child at present:

___ Mostly quiet
___ Tires easily
___ Too impulsive
___ Stubborn
___ Over reacts
___ Usually happy
___ Clumsy
___ Has difficulty separating from primary caretakers
___ Falls often
___ Rocks self frequently
___ Overly active
___ Difficulty regulating emotions
___ Talks constantly
___ Restless
___ Resistant to changes in routine
___ Fights frequently
___ Exhibits frequent temper tantrums
___ Has nervous habits or tics
___ Wets bed
___ Easily frustrated
___ Cries easily
___ Has difficulty learning new tasks
___ Has difficulty organizing personal belongings

Comments:

3. Give approximate ages at which child did the following routinely:

_____ Held up head
_____ Rolled over
_____ Sat alone
_____ Belly crawled (while on stomach)
_____ Crawled on hands and knees
_____ Pulled to standing
_____ Stood alone
_____ Walked

4. General impression of child's motor development:
Gross Motor: slow_____ normal_____ advanced_____
Fine Motor: slow_____ normal_____ advanced_____
Poor handwriting: yes_____ no_____
Any discrepancies in your impressions versus the schools? yes_____ no_____

If yes, explain_____

5. Self-care:
Bottle-fed yes_____ no_____ type of formula_____
Nursed yes_____no_____ How long?_____
Problems with either? yes_____ no_____ If yes, explain_____
_____

Currently eats: _____ Breast milk _____ Formula
_____ Baby food _____ Junior foods
_____ Mashed table foods _____ Table foods
_____ Objects to certain foods (textures, taste, etc.) List most common:
_____

Describe degree to which child routinely performs the following:
Feeds self: all_____ most_____ some_____ rarely_____
If feeds self, uses: bottle_____ fingers_____ spoon_____ fork_____
Bathes self: all_____ most_____ some_____ rarely_____
Dresses/Undresses self: all_____ most_____ some_____ none_____
Is child toilet trained? yes_____ no_____ If yes, at what age?_____

6. Check which of the following describe your child's sleep habits:
___ Is an early riser ___ Awakens during the night ___ Has difficulty falling asleep
___ Wets bed ___ Is irritable upon awakening ___ Has good sleep patterns

7. Has child achieved skills and then lost them?_____ if so, what and when_____
_____

SENSORY HISTORY

1. Vestibular (movement and gravity information). Check which of the following applies to your child:
___ Rocks while sitting
___ Likes being tossed in air/roughhousing
___ Fearful of heights
___ Likes merry-go-rounds
___ Enjoys being rocked now or as infant
___ No fear of movement or falling
___ Jumps a lot
___ Good balance
___ Fearful of movement
___ Spin & whirl more than other children
___ Gets car sick
___ Prefers more quiet play as opposed to more active play
Comments:

2. Tactile (touch information). Check which of the following applies to your child:
___ Avoids "messy" things (mud, fingerpaint, etc.)
___ Irritated by cloth or certain textures
___ Dislikes unexpected touch
___ Prefers to touch rather than be touched
___ Bangs head on purpose (now or in past)
___ Examines objects by putting them in mouth
___ Isolates self from other children
___ Excessively ticklish
___ Dislikes nail cutting
___ Dislikes having face washed or wiped
___ Objects to being touched
___ Dislikes being cuddled
___ Avoids using hands for extended periods
___ Pinch, bite or otherwise hurt others
___ Tends to feel pain less than others
___ Strong likes or dislikes toward food textures
___ Dislikes hair washing
___ Wants to handle everything
___ Seeks lots of touch
Comments:

3. Proprioceptive (muscle and joint information): Check which of the following applies to your child:

___ Holds hands in strange positions
___ Walks on toes (or did when younger)
___ Crept on tummy rather than hands or knees
___ Leaps from one position to the next, unable to move slowly from one to another
___ Seeks movement (i.e., falls on purpose)
___ Exerts too much pressure (i.e., slams doors, breaks pencils/crayons)
___ Chews on clothing or objects
___Good coordination with small things (i.e., pencil, buttons)
___ Went from sitting to standing with little or no crawling
___ Uses too much pressure when writing
___ Weak grasp or loose grasp
___ Grinds teeth
___ Jumps a lot

Comments:

4. Auditory: Check which of the following applies to your child:

___ Responds negatively to unexpected or loud noises
___ Misses hearing some sounds
___ Seems to enjoy strange noises and/or make loud noises
___ Enjoys music
___ Becomes anxious or irritable when anticipating loud noises or events
___ Has difficulty paying attention when there are other noises nearby
___ Seems confused as to the direction of sounds
___ Appears to be hard of hearing
___ Responds negatively to everyday noises (i.e., vacuum, hair dryer, toilet flushing)

Comments:

5. Visual: Check which of the following applies to your child:

___ Reversals in copying
___ Looks very closely and carefully at pictures or objects
___ Becomes very excited when there is a variety of visual objects
___ Have difficulty maintaining eye contact with another person
___ Sometimes shakes head in awkward manner
___ Shifts head to one side in order to look at an object
___ Sensitive to bright lights, sunlight
___ Has difficulty discriminating shapes or colors
___ Resists having eyes covered
___ Have difficulty visually focusing on things far away
___ Have difficulty focusing on things close
___ Wears glasses
___ Difficulty following an object across the room
___ Difficulty following an object tossed toward him/her

Comments:

6. Gustatory-Olfactory (taste and smell information): Check which of the following applies to your child:

___ Has limited diet - “picky eater”
___ Acts as though all food tastes the same
___ Dislikes foods of certain textures
___ Discriminates odors
___ Ignores unpleasant odors
___ Chews on nonfood objects
___ Has unusual cravings for certain foods
___ Explores by smelling
___ Reacts negatively to smell

Comments:

SPEECH/LANGUAGE HISTORY

1. Give approximate ages at which your child did the following:
   Babbled _____ Said first word _____ What were the first words?_____
   Combined two words _____ Give example _____
   Used 3-4 word sentences _____ Give example _____
   Obeyed simple commands _____
   History of "losing" basic words? (used them, then stopped) (circle) No / Yes _____ at what age?

2. ___ I have no concerns about my child's speech & language development. (Go to School Information)

3. Check those which describe your child's ability to use spoken language: (if applicable)
   ___ Responds to greetings
   ___ Makes requests ___ Verbally ___ Nonverbally
   If your child is nonverbal, please describe how he/she communicates. Please be specific:
   _____
   _____
   ___ Makes eye contact
   ___ Makes no sound or on a very limited basis
   ___ Language is limited to gestures
   ___ No true words
   ___ Language is limited to single words or short phrases
   ___ Uses simple sentences
   ___ Sentences are long but disorganized and hard to understand
   ___ Words are difficult to understand
   ___ Voice quality is unusual (hoarse, nasal or earthy, high-pitched)
   ___ Has difficulty recalling/retelling recent events
   ___ Has trouble remembering the correct names of things
   ___ Engages in conversation with others
   ___ Has no apparent problems expressing himself/herself
   ___ Seems frustrated at trying to relate events
   ___ Stutters frequently
   ___ Hesitates frequently
   ___ Repeats words/sentences
   ___ Repeats initial consonants (e.g., ba, ba, boy)
   ___ Prolongs sounds (e.g., sssssssong)
   ___ Uses words that don't communicate particular meaning
   ___ Answers "wh" questions (who, what, why)

Comments on any of the above:

3. Check those which apply to your child's listening habits:
   ___ Responds only to loud sounds
   ___ Responds as if sound is painful
   ___ Seems to hear properly
   ___ Seems to ignore people when they are talking to him/her
   ___ Seems uninterested

4. Check which statements best describe your child's ability to understand language:
   ___ Understands no spoken language
   ___ Understands a few words
   ___ Understands most words
   ___ Follows simple commands
   ___ Understands simple conversation
   ___ Understands almost everything that is said to him/her

5. At present, how much of your child's speech can be understood?
   By mother: all _____ most _____ some _____ none _____
   By other family members: all _____ most _____ some _____ none _____
   By neighbors: all _____ most _____ some _____ none _____

6. If applicable, describe your child's speech problem (give examples):

7. If applicable, how severe do you think this problem is? severe _____ moderate _____ mild _____

8. Is your child aware of the problem? _____ How does he/she react? _____
   _____

9. Is any language other than English used in the home? _____ If yes, what language _____ What percent of the time?_____

SCHOOL INFORMATION

1. School:_____ School District: _____
   Grade:_____ School Days:_____ a.m._____ p.m._____ all day_____
   Teacher:_____ Grades repeated? _____Skipped? _____

2. Child is/has been in a special classroom, remedial classes and/or receives(d) OT, PT, ST? Yes__ No__

   If so, describe what type, where, when? _____
   _____

3. Check which of the following you or child's teacher have observed:

   ___ Functions better in a one-to-one relationship than in classroom situation
   ___ Has to be reminded how to hold his pencil/paper when writing
   ___ Needs to prop head in his/her hand while reading or writing at the desk
   ___ Shows a hand preference
   Which hand does he/she prefer for:
   Feeding: R ___ L ___ Crayon/Pencil: R ___ L ___ Throwing: R ___ L ___
   Pointing: R ___ L ___ Cutting: R ___ L ___
   If he/she prefers the left hand, are there other left handers in the family?_____

   ___ Noticeably distracted in class
   ___ A poor speller
   ___ Plays with siblings
   ___ Tends to prefer to play with younger children
   ___ Confused in right-left discrimination tasks
   ___ Good at making friends easily
   ___ A loner
   ___ Tends to prefer the company of adults

4. What academic skills are the hardest?_____

   _____