Grand Valley
Pediatric Therapy
Community HOSPITAL

Scheduling Communication Preference

Please Print

Patient Name: ___________________________________ **Date of Birth:** _________________

In an effort to protect your privacy while allowing for efficient scheduling, please answer the following questions on how to contact you regarding scheduling issues:

□ No, it is NOT ok to leave messages or voicemails.
□ Yes, it is ok to leave messages or voicemails.

Preferred contact numbers where we may leave a message if answered yes:

□ Home Phone: (   ) ________________ □ Work Phone: (   ) ________________ □ Cell Phone: (   ) ________________

Persons authorized to receive messages/information at the above numbers for scheduling

____________________________________ ____________________________________
Name Relationship Name Relationship

Only the people listed above will be able to confirm or change your appointment.

Please note: Above authorized persons requesting information, including appointment confirmations and changes, **must** provide us with information about you including name, date of birth and zip code. In the event of an unforeseen circumstance, and the parent/guardian cannot pick up their child, the parent/guardian must call Grand Valley Pediatric Therapy and provide the office with the name and phone number of the person who will pick up the child. A picture ID/photograph is required when the person arrives.

Thank you for assisting us.

If the above was answered yes, it is ok to leave messages or voicemails, I authorize Community Hospital's Grand Valley Pediatric Therapy to leave protected health information inquiries that may include the following: name of patient, name and phone number of the clinic; name of treating therapist(s), appointment times and dates and scheduling information/requests.

____ ______________________________
Signature Date

Relationship, if not patient: ______________________________________

Pediatric Cancellation Policy

Dear Valued Patient,

Thank you for choosing Community Hospital's Grand Valley Pediatric Therapy for your family's therapy needs. Due to the volume of new patients and limited appointments, we require patients to notify our office 24 hours in advance if they are unable to keep your appointment. We do understand emergencies arise. In such cases, please contact us as soon as possible to cancel or reschedule your appointment. If your child is running fever or showing any sign of illness, please call and cancel their appointment, as well as subsequent appointments until they are asymptomatic. If an appointment is canceled less than an hour prior to scheduled time, this may be considered a No Show Appointment.

Therapy is a process that takes time, and unfortunately we cannot predict exactly how long it will take as each individual is different. A vital component is consistency, according to what was recommended by the treating therapist. In order for treatment to be effective, attendance is key. With this in mind, along with the volume of patients and limited number of appointments, we will require your child maintain 75 percent or greater attendance. If your child falls below 75 percent attendance, the treating therapist will alert you and will take into consideration cancellations due to emergencies. If your child falls below 60 percent attendance, the treating therapist may consider discharging your child from Grand Valley Pediatric Therapy.

Failure to call and cancel an appointment is considered a No Show Appointment. After two such occurrences, any additional scheduled appointments may be canceled. Your therapist may consider discharging your child from treatment, and will contact you and send a note to your physician indicating non-attendance. You will have to contact your therapist to discuss continuation of therapy.

To cancel or reschedule an appointment, please call (970) 644-3720.

Along with quality treatment, we strive to treat patients at their scheduled time. If you are more than 10 minutes late for your appointment, your appointment may need to be rescheduled.

Co-pays are collected prior to each treatment. Failure to pay may result in a bill from Community Hospital's billing department.

Thank you again for choosing Community Hospital for your health care needs! We want to meet the goals of all of our patients and we appreciate your assistance in the matter.

Kyle Gardner, CCC-SLP
Director, Grand Valley Periatric Therapy
Community Hospital

________________________________ ____________________
Parent/Guardian Signature Date

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Speech, Physical, Occupational Therapy Intake Questionnaire

Name: ____ **Nick Name:** __________________

DOB: __________________ **Age:** _____________ **Grade:** ______________________

Parents' Names: ________________________________

Phone Number: _________________________________ **Email:** ______________________

Address: ______________________________________ **City:** _______________________

Pediatrician: _______________________ **Referring Physician:** ______________________

Diagnosis: ____

Medication(s)/Dosage: ____

Allergies: ____

Insurance

Primary Insurance: ____________________________ **Phone:** ______________________

ID# ____ **Group#** _____________________

Policy Holder Name: ___________________________ **DOB:** ________________________

Secondary Insurance: __________________________ **Phone:** ______________________

ID# ____ **Group#** _____________________

Policy Holder Name: ___________________________ **DOB:** ________________________

Prenatal and Neonatal History

Full Term: Yes No If no, weeks? ____________ Birth Weight: ________lbs________oz

Vaginal Delivery:	Yes	No	Cesarean Section	Yes	No
Hospitalization:	Yes	No	Extended Hospital Stay	Yes	No
NICU:	Yes	No	Oxygen	Yes	No
Incubator:	Yes	No	Surgery	Yes	No

Medical History

Major Illness: ____

Chronic Health Conditions: ____

History of ear infections: ____

Any other health problems during infancy: _______________________________________

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Speech, Physical, Occupational Therapy Intake Questionnaire

Developmental Milestones (please indicate approximate age)

Roll ________ Sit _________ Belly Crawl _______ Crawl on hands/knees ____________ Walk _______

Babble ____________ First Word _________ 2 word combinations ______ Sentences _________

Child Information

What kinds of things does your child enjoy? ____

____

What things about your child do you especially enjoy? ______________________________________

____

What are your child's gifts? ____

Pertinent Information

Parents: Married Divorced **Siblings:** Yes No How Many:_______________

When did parents become concerned? ____

Does your child have **frequent meltdowns?** Yes No **Aggressive?** Yes No

What triggers meltdowns? ____

How long do they last? ____

What do your child's meltdowns look like? ____

What calms them down? ____

Do you have any **concerns regarding mental health?** Yes No

Play/Social Skills

Describe the play activities your child engages in: ______________________________________

____

Does your child **play interactively with his/her peers?** Yes No

Does your child make friends? Yes No Maintain friendships? Yes No

Does your child have friends in school/daycare and/or outside of school/daycare? Yes No

Does your **child prefer to play alone?** Yes No With others? Yes No

How does your child interact with his/her siblings, parents, caretakers? ____________________________

____

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Speech, Physical, Occupational Therapy Intake Questionnaire

Academics

Is your child attending: daycare preschool elementary school All day half day

Name of school/daycare: ______________________________

Any difficulties/areas of concern at school? ______________________________

Is your child on an IEP? Yes No *If yes, please bring a copy of the most recent IEP******

Activity level/Attention Span

Do you consider your child's activity level for their age to be average, over-active, or under-active?

____

Describe your child's attention span: ______________________________

Community Settings

Does your child have any difficulties when in stores, malls, restaurants, etc? (such as uncontrollable touching, sensitivity to noises, lights) Yes No

Does your child become **overstimulated by the activity** around him/her? Yes No

What response does he/she have to overstimulation? ______________________________

Transitions

Does your child have difficulties with transitions? Yes No

Describe these difficulties during transitions: ______________________________

____

Major Concerns

What are you most concerned about now? ______________________________

____

Has your child previously received any therapies?

PT	Yes	No	Where? ______________________________
OT	Yes	No	Where? ______________________________
Speech	Yes	No	Where? ______________________________
Feeding	Yes	No	Where? ______________________________
Behavioral	Yes	No	Where? ______________________________

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Speech, Physical, Occupational Therapy Intake Questionnaire

Speech/Language Therapy Questionnaire

Why are you seeking speech/language therapy services for your child? ______________________________

____

When was the problem/concern first noticed? ____

Is the child aware of the problem? Yes No

What languages are spoken in the home? ____

How does your **child typically communicate?** Gestures Sign language Single words

Short phrases Sentences Other (please describe) ______________________________________

Does your child:

Respond to sound	Yes No	Respond inconsistently	Yes	No
Respond to name	Yes No	Ignores sounds willfully	Yes	No
Follow simple directions	Yes No	Respond correctly to yes/no	Yes	No

Respond correctly to "wh" questions (where, what, when, who, why) Yes No

Has your child had a hearing screening or evaluation? Yes No

When? ______________________________ Results: ______________________________________

Physical Therapy Questionnaire

Why are you seeking physical therapy services for your child? ______________________________

____

When was the problem/concern first noticed? ____

Is the child aware of the problem? Yes No

Does your child complain of pain? Yes No

Is yes, please describe type and frequency: ____

____

Please state whether your child can perform the following activities **(I) independently or (NH) needs help**

Walk up/down stairs: I ____ NH _____ Walk: I ______ NH _____

Jump off step/curb: I ____ NH _____ Run: I _______ NH _____

Does your child "W" sit? Yes No

Do you have any concerns for your child's gross motor development? Yes No

If yes, please explain: ____

Does your child participate in age appropriate movement activities (e.g. riding a bike, skipping)?

Yes No

Speech, Physical, Occupational Therapy Intake Questionnaire

Occupational Therapy Questionnaire

Why are you seeking Occupational Therapy services for your child?______________________________

____

When was the concern/problem first noticed? ____

____

Is the child aware of the problem? Yes No

Does your child do better with a structured routine? Yes No

Describe what happens if the routine is altered: ____

____

Response to Sensory Stimuli (please describe):

Tactile

Does your child exhibit any sensitivity to the feel of fabrics, socks, shoes, etc? Yes No

Is your child bothered during tasks such as hair brushing/washing, bathing, nail cutting, teeth brushing, etc.? Yes No

Does your child get upset when they are touched by others? Yes No

Does your child have a tendency to touch other people or objects without control or recognition of boundaries or social appropriateness? Yes No

Please describe: ____

Vestibular

Is your child overly cautious/fearful when performing movement or movement related activities? Yes No

Does your child dislike being off balance? Yes No

Does your child seek out movement? Yes No

Does your child seek out intense movement to a greater degree than peers, such as spinning, jumping, and hanging? Yes No

Proprioceptive

When manipulating objects, does your child tend to hold the object too tight or too loose? Yes No

When you assist your child with a physical task such as dressing or getting in the car, does your child over anticipate or under anticipate the movement? Yes No

Does your child bump into things, misinterpret, or misjudge movement? Yes No

Auditory:

Does your child exhibit sensitivity to sound? Yes No

Visual:

Does your child exhibit any sensitivity to visual stimuli? Yes No

Does your child focus on visual stimuli? Yes No

Does your child avoid eye contact in social interactions? Yes No

Speech, Physical, Occupational Therapy Intake Questionnaire

Gustatory/Olfactory

Does your child eat a variety of foods and textures? Yes No

Does your child have any food allergies or sensitivities? Yes No

Does your child have sensitivities to smells? Yes No

Sleep

What time does your child go to bed? __________________ Wake up? ______________________

Does your child have problems falling asleep? Yes No

Do they wake up frequently at night? Yes No

Does your child have difficulty waking up in the morning? Yes No

Activities of Daily Living

Please state whether your child can perform the following activities **independently (I) or needs help (NH)**

Toileting:	I	NH	Bathing:	I	NH
Brushing hair:	I	NH	Brushing teeth:	I	NH
Dressing:					
T-shirt	I	NH	Shirt w/ buttons	I	NH
Pants	I	NH	Socks	I	NH
Shoes	I	NH	Tying shoes	I	NH
Jacket	I	NH			

Can your child pick out an appropriate outfit? I NH

How long does it take your child to get dressed? ____

Feeding:					
Use cup	I	NH	Use spoon	I	NH
Use fork	I	NH	Use knife	I	NH

Does your child use a standard tripod grip? Yes No

What is your child's dominant hand? Right Left Both

In our efforts to provide the most effective therapy services, please list the areas of function that you would like to see change over the course of therapy for your child.

____

____

Is there anything else you would like us to know about your child, you, or your family that will help us support all of you through this journey?

____

____