Making Better Lives.
Rock Valley
PHYSICAL THERAPY

Pediatric Medical History/Intake

Name: ____ **Date of Birth:** ________________ **Today's Date:** ________________

Parents/Guardian Name: ____

Siblings (Name & Age): ____

Diagnosis: ____ **Onset Date:** _________________________________

1: Has your child ever been diagnosed with any of the following conditions (check all that apply)?

- ☐ ADHD
- ☐ Allergies ___________________________________
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism
- ☐ Autoimmune disorder
- ☐ Blood/Clotting disorder
- ☐ Cancer ______________________________________
- ☐ Cardiac Conditions ___________________________
- ☐ Cerebral Palsy
- ☐ Depression
- ☐ Diabetes
- ☐ Feeding/eating issues
- ☐ Fractures ____________________________________
- ☐ Genetic Disorders _____________________________
- ☐ Ear Infections ________________________________
- ☐ Epilepsy
- ☐ Hearing Impairment __________________________
- ☐ HIV/AIDS
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Lung problems
- ☐ Metal implants
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Speech/Language problems
- ☐ Toe Walking
- ☐ Torticollis
- ☐ Vision impairments
- ☐ Other: ______________________________________

2: Surgical History & Date:

- ☐ Adenoids ____________________________________
- ☐ Hernia ______________________________________
- ☐ Tonsils ______________________________________
- ☐ Tubes ______________________________________
- ☐ Other ______________________________________

3: Medications: ____
____

4: Does your child have a special diet or food restrictions? ____

5: Sleeping Habits:

- ☐ Sleeps all night
- ☐ Wakes up frequently
- ☐ Difficulty getting to sleep
- ☐ Only sleeps with medication
- ☐ Other ______________________________________

6: Release of Information

- ☐ AEA: ____
- ☐ Community Services: _____________________________
- ☐ Orthotist: _______________________________________
- ☐ School: ____
- ☐ University of Iowa Hospitals & Clinics: ______________________________________
- ☐ Wheelchair: __________________________________
- ☐ Other: ______________________________________

7: Public Release:

I hereby give my permission to have my child photographed or videotaped and utilized by Rock Valley Physical Therapy for educational and/or marketing purposes. ☐ Yes ☐ No Initials __________

Parent/Guardian Signature: _________________________________ **Relationship** _____________________ **Date** ______________

PATIENT DEMOGRAPHIC INFORMATION

Date ______________________

First _________________________ **MI** _______ **Last** _________________________ **DOB** ______________ **Age** __________

Male / Female **Married / Single / Widowed / Child** **Soc. Sec. #** ______________________________________

Home Address ____

City _________________________ **State** ______ **Zip** ___________ **Email** ____________________________________

Home# __________________________ **Cell#** ___________________________ **Work#** ____________________________

Employer ____ **Occupation** _________________________________

Emergency Contact ____ **Phone#** ___________________________

How did you hear about our office? ____

IF PATIENT IS A MINOR:

Father: **Name** ____ **Phone#** ________________________

Mother: **Name** ____ **Phone#** ________________________

INSURANCE INFORMATION

Primary Insurance _____________________________ Policy Holder Name __________________________________

Policy Holder DOB __________________________ Relationship ____

Secondary Insurance ___________________________ Policy Holder Name __________________________________

Policy Holder DOB __________________________ Relationship ____

HOME ADDRESS OF POLICY HOLDER if different than patient's ____

____

Is this a liability injury? **Yes** ☐ **No** ☐ If yes, please check one: **Worker's Comp** ______ **Auto** ______ **Other** ______

Claim#: _________________________________ **Contact Person** ________________________ **Phone** ________________

Are you being represented by an attorney? **Yes** ☐ **No** ☐

If yes:

Attorney Name ____ **Phone** _______________________

Address ____

I acknowledge that I have reviewed the information listed and confirm that there are no changes to my demographic and insurance information.

Initials _________ Date _________________ Initials _________ Date _________________ Initials _________ Date _________________

Initials _________ Date _________________ Initials _________ Date _________________ Initials _________ Date _________________

Welcome to Rock Valley Physical Therapy

Thank you for choosing Rock Valley and providing us the opportunity to work with you.
We hope to exceed your expectations and assist you in achieving your goals.

Notice of Privacy Practices:
I acknowledge being offered Rock Valley Physical Therapy's *Notice of Privacy Practices* pamphlet. I have initialed here to indicate that I understand my rights through HIPAA and that I am declining this pamphlet. (*Initial Here)* __________

Authorized Person(s):
I authorize you to speak to________________________ , ________________________, ________________________,

________________________, ________________________ , regarding my account and/or treatment.

By checking the box, I indicate that I do NOT want my Primary Care Physician (PCP) contacted regarding my care: ☐

Authorization to Release Information:
I authorize the release of any medical or any other information to the Centers for Medicare and Medicaid Services (CMS), my insurance carrier(s), or other entities necessary to determine insurance benefits or the benefits payable for related medical services and /or supplies provided to me by Rock Valley Physical Therapy.

Financial Responsibility:
I understand that insurance billing is a service provided as a courtesy and that I am, at all times, financially responsible to Rock Valley Physical Therapy. It is my responsibility to notify Rock Valley Physical Therapy of any changes in my health care insurance coverage. If the submitted charges or any part of them are denied for payment, I am responsible for the balance. I request that payment of my services be made on my behalf to Rock Valley Physical Therapy. I understand that by signing this form, I am accepting financial responsibility, as explained above, for payment of the balance of all medical services. I also understand that Rock Valley Physical Therapy collects for copayments at the time of service.

Supply Items:
I understand that Rock Valley Physical Therapy may, during the course of treatment, recommend purchase of a supply item. Supply items may or may not be covered under my insurance plan. I understand that it is my financial responsibility to pay for any item in full if it is not covered under my insurance plan.

This is to verify that I have read and agree with the above.

____ ________________________________
Patient or Responsible Party Date

Home Address of *Responsible Party* if different than the Patient:

____

Non-Discrimination Policy:

Rock Valley Physical Therapy does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact the administrative assistant at (309)-743-2070. TDD/Relay Iowa.