PATIENT INTAKE FORM

A) BASIC INFORMATION

Last name: _____ First: _____

Nick Name: _____ Gender (circle one): M / F

Child's D.O.B.: _____/_____/_____ Age: _____ yrs/ mos

Address: _____

_____

Home Phone #: (____)_____ Fax #: (____)_____

PARENT'S NAMES:

Parent A: _____

Dad ☐ Mom ☐ Grandparent ☐ Other ☐ _____

Cell #: (____)_____ Work #: (____)_____

E- mail: _____

Parent B: _____

Dad ☐ Mom ☐ Grandparent ☐ Other ☐ _____

Cell #: (____)_____ Work #: (____)_____

E- mail: _____

B) MD'S NAME / ADDRESS PHONE

Pediatrician: _____ #: (____)_____

Neurologist: _____ #: (____)_____

Ortho: _____ #: (____)_____

Cardiac/ Pulmonary: _____ #: (____)_____

Other: _____ #: (____)_____

Other: _____ #: (____)_____

I hereby allow Novogrow, LLC to contact the above doctors and share pertinent medical information to enhance my child's care.

_____ _____/_____/_____

Parent's signature Date

C) Who can we thank for referring you? _____

Address: _____

_____

Phone #: (____)_____ E- mail: _____

D) INSURANCE INFORMATION

ID #: _____

Provider/ Company: _____

Group #: _____

Policy #: _____

INSURED'S INFORMATION

Last name: _____ First: _____

D.O.B.: _____/_____/_____ Gender (circle): M / F

Address (If different from patient's):

_____

_____

Relationship to patient: _____

Phone #: (____)_____ Fax #: (____)_____

E- mail: _____

Plan Name: _____

EMPLOYER

Business Address: _____

_____

Business Phone #: (____)_____

E) DIAGNOSIS: _____

1) Why do you want to see me? What do you hope to gain from therapy?

_____
_____
_____
_____
_____
_____

2) What is your child capable of doing now in terms of Gross Motor Movement?
(Check what applies)

Can your child. . . .	Easily	With Difficulty	Not At All
- Hold head upright on belly: ……...	☐	☐	☐
- Roll back to belly: …….	☐	☐	☐
- " belly to back: ……	☐	☐	☐
- Sit when placed with arms: ……...	☐	☐	☐
- " " " w/o arms: …….	☐	☐	☐
- Reaches and plays in sit: …….	☐	☐	☐
- Move from sit to belly: ……...	☐	☐	☐
- Come to sit from belly: …….	☐	☐	☐
- from back: …….	☐	☐	☐
- Crawl on belly: ……	☐	☐	☐
- Come to hands & knees: ……...	☐	☐	☐
- Crawl on hands & knees: …….	☐	☐	☐
- Takes weight on legs when held: ……	☐	☐	☐
- Pull to stand on furniture: …….	☐	☐	☐
- " " " on wall: ……...	☐	☐	☐

- Takes steps w/ arm(s) held:
  ☐ overhead # steps:_____ ☐ 2 arms #:____ ☐ 1 arm #:_____
- Stands free: How Long:_____
- Takes steps free (free walking)
  How many? _____
  % of day walking: _____%
- Climbs stairs How many? _____
  ☐ 2 arms ☐ 1 arm ☐ with railing ☐ free
- Descends stairs How many? _____
  ☐ 2 arms ☐ 1 arm ☐ with railing ☐ free
- Falls frequently? Y / N How often?: _____
- Avoids obstacles? Y / N Sometimes: _____

3) Birth History:

- Was your child born prematurely? Y / N
  How much? (Gestational Age): _____
  How long? _____
- Intubated? Y / N How long? _____
- On oxygen? Y / N How long? _____

4) Medical History:
   - Does your child have seizures? Y / N
     Now? Y / N
     History of last one: _____
     Only with fever? Y / N
     Currently controlled by medication?
   - History of brittle bones? Y / N
   - Are joints located primarily on hips? Y / N
   - Last hip x- ray? ____/___/_____
   - Scoliosis? Y / N
     Last back x- ray: ____/___/_____
   - Does your child take any medications? Y / N
     (Please list name and for what.)

     1) _____

     2) _____

     3) _____

     4) _____

_____ _____/_____/_____
Parent's signature Date