Jump Start
Pediatric Therapy

New Patient Information Form

PERSONAL INFORMATION

Patient's Name _____ ☐ Male ☐ Female
Date of Birth (MM/DD/YYYY) _____ Age _____
Guardian Name _____ Occupation _____
Guardian Name _____ Occupation _____
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Co-habitate
Parental Status ☐ Biological ☐ Adoptive ☐ Foster ☐ Legal Guardian
With whom does the child reside? _____
Siblings' names and ages _____
Mailing Address _____ Apt/Suite _____
City _____ State _____ Zip _____
Email Address: _____
(Required to view appointments, receive invoices, pay bills, and access records through patient portal).

Please check left box if we may leave messages regarding your child's therapy at this number.

☐ Primary Phone (____)_____ is ☐ Cell ☐ Home ☐ Work ☐ Mom ☐ Dad ☐ Guardian 1
☐ Second Phone (____)_____ is ☐ Cell ☐ Home ☐ Work ☐ Mom ☐ Dad ☐ Guardian 2

Emergency Contact (**required**)
Name _____ Relationship _____ Phone (_____)_____

REFERRAL INFORMATION

Diagnosis / Reason for referral to therapy _____
Referring Provider (doctor and office name) _____
Primary Care Provider (doctor and office name) _____
Dentist (doctor and office name) _____
What goals would you like for your child to achieve? _____

PRENATAL HISTORY

☐ Foster or adoptive parent with limited knowledge of birth history

Please indicate if any of the following occurred during the mother's pregnancy:

			Please Describe
Infections	☐ Yes	☐ No	_____
Illnesses	☐ Yes	☐ No	_____
Medications	☐ Yes	☐ No	_____
Drug or Alcohol Exposure	☐ Yes	☐ No	_____
Significant Stress or Life Change	☐ Yes	☐ No	_____
Other Complications	☐ Yes	☐ No	_____

Patient Name _____ Date of Birth _____

BIRTH HISTORY

☐ Foster or adoptive parent with limited knowledge of birth history

Birth ☐ Single ☐ Twin A ☐ Twin B ☐ Multiple # _____

Delivery Birth Weight Pounds _____ Ounces _____
☐ Full-Term ☐ Premature (delivered at _____ weeks)
☐ Vaginal ☐ Planned C-Section ☐ Emergency C-Section
☐ Unassisted ☐ Assisted by Forceps ☐ Assisted by Suction

Complications ☐ Breech ☐ Nuchal Cord (wrapped around neck)
☐ Multiple Birth ☐ Premature Rupture of Membranes
☐ Meconium Aspiration ☐ Fetal Distress
☐ Other: _____

Following Delivery ☐ Regular Nursery ☐ Special Care Nursery ☐ NICU
Length of hospital stay? _____

Baby required support for ☐ Jaundice ☐ Feeding ☐ Breathing
Additional Information _____
_____

MEDICAL HISTORY

			Please Describe (date and frequency if applicable)
Immunizations Current	☐ Yes	☐ No	_____
Hospitalizations	☐ Yes	☐ No	_____
Surgeries	☐ Yes	☐ No	_____
Seizures	☐ Yes	☐ No	_____
Heart Problems	☐ Yes	☐ No	_____
Breathing Difficulties	☐ Yes	☐ No	_____
Allergies	☐ Yes	☐ No	_____
Nutritional Concerns	☐ Yes	☐ No	_____
Feeding Difficulties	☐ Yes	☐ No	_____
Reflux	☐ Yes	☐ No	_____
Ports, Tubes, or Shunts	☐ Yes	☐ No	_____
Casts or Braces	☐ Yes	☐ No	_____
Skin Breakdown	☐ Yes	☐ No	_____
Ear Infections	☐ Yes	☐ No	_____
Pain Issues	☐ Yes	☐ No	_____
Vision Concerns	☐ Yes	☐ No	_____
Hearing Concerns	☐ Yes	☐ No	_____
Bowel or Bladder Concerns	☐ Yes	☐ No	_____
Physical/Emotional Trauma	☐ Yes	☐ No	_____

Other (please describe) _____
Current Medications _____
_____

Patient Name _____ Date of Birth _____

EDUCATION AND THERAPY HISTORY

Does your child participate in the Infant Toddler Program (early intervention)? ☐ Yes ☐ No
If yes, therapy and frequency? ☐ PT _____ ☐ OT _____ ☐ Speech _____

Is your child enrolled in Early Head Start or Head Start? ☐ Yes ☐ No

Is your child currently enrolled in school? ☐ Yes ☐ No
If yes, name of school? _____ Grade Level _____

Does your child receive therapies as part of an IEP or 504 plan at school? ☐ Yes ☐ No
If yes, therapy and frequency? ☐ PT _____ ☐ OT _____ ☐ Speech _____

Does your child receive Habilitative or Behavioral Intervention services? ☐ Yes ☐ No
If yes, name of agency? _____

Does your child participate in other outpatient therapies? ☐ Yes ☐ No
If yes, therapy and frequency? ☐ PT _____ ☐ OT _____ ☐ Speech _____

DEVELOPMENTAL HISTORY

At approximately what age did your child begin to do the following without help?

Roll Over	_____	Jump	_____	Button	_____
Sit	_____	Ride Bike	_____	Tie	_____
Crawl	_____	Say 1st Word	_____	Drink from cup	_____
Walk	_____	Say sentence	_____	Eat table food	_____
Run	_____	Zip	_____	Eat with utensil	_____

How well does your child sleep? _____

Any concerns related to feeding or mealtimes? _____
If under 2 years old: ☐ Breast ☐ Bottle ☐ Baby Food ☐ Table Food

Does your child have any behavioral concerns? If yes, how do you currently manage undesired behaviors?

_____

_____

_____

Do you have any concerns with bowel or bladder function? ☐ Yes (describe below) ☐ No

_____

Do you have religious, dietary, or cultural needs that you would like for us to be aware of?

_____

_____

Please let us know if specific days or times work well (or do not work at all) for your child to attend therapy. We will make every effort to accommodate your requests as our schedule permits.

_____

_____

Patient Name _____ Date of Birth _____

CONSENT

Consent to Treat: As the parent or legal guardian of _____, I authorize Jump Start Pediatric Therapy to provide his/her therapy evaluation and treatment.

_____ Parent/Guardian Initial

Consent to Patient Information Practices: I have received and agree to Jump Start Pediatric Therapy's Notice of Patient Information Practices.

_____ Parent/Guardian Initial

Communication Preferences: I prefer the following methods of communication:

☐ Please text appointment reminders to the primary contact phone number.

☐ Please email appointment reminders to the primary contact email address (email required).

☐ I consent to email communication regarding my child's care. I understand and accept the security risk of sharing protected health information by email.

_____ Parent/Guardian Initial

_____ _____
Parent / Guardian Signature Date

_____ _____
Therapist Signature Date

_____ _____
Therapist Signature Date

_____ _____
Therapist Signature Date

_____ _____
Therapist Signature Date