



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:

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please Describe
Infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Illnesses	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drug or Alcohol Exposure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Significant Stress or Life Change	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Complications	<input type="checkbox"/>	<input type="checkbox"/>	_____

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hospitalizations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Surgeries	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Breathing Difficulties	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Nutritional Concerns	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Feeding Difficulties	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Ports, Tubes, or Shunts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Casts or Braces	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Skin Breakdown	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Ear Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Pain Issues	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Vision Concerns	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hearing Concerns	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bowel or Bladder Concerns	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Physical/Emotional Trauma	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 1 st 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.

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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:

I consent to **text or email** communication for appointment reminders, schedule change notifications, office closures, and time-of-service payment reminders (if applicable).

I consent to **text or email** communication regarding my child's treatment plan of care.

_____ Parent/Guardian Initial

Parent / Guardian Signature

Date

Therapist Signature

Date

Therapist Signature

Date

Therapist Signature

Date

Therapist Signature

Date