6520 3rd Street Rockledge, FL 32955 P (321) 622-8792 F (321) 622-8793

Physical Therapy
Case History Form

Child's Name:____ Date of Birth________________

Father's Name:____ Cell Phone__________________

Mother's Name:____ Cell Phone_________________

Home Address:____

City________________________________ State________________ Zip___________________________

Child resides with:____

Father's email address:____

Mother's email address:____

I do wish to allow email communication ____________________

I DO NOT wish to allow email communication________________

Child's School__________________________ Grade__________ Teacher______________________________

Insurance Information

Insured's Name (if different from patient)____

Relationship to patient:_______________________________ Date of birth____________________________

Insurance:____

Group#______________________________ ID or SS#____

Insurance Phone____

Referred by____

Doctor's Name____

Dr. Address:____ Phone_______________________________

Family History:

Siblings:__________________________ Age:__________

__________________________ Age:__________

__________________________ Age:__________

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Birth and Medical History

Vaginal birth_____________ Full Term__________ Caesarean section__________ Premature birth____________

Was there anything unusual about the pregnancy or birth?____________Yes ____________________No

If yes, please explain____

Was the mother sick during pregnancy? ____________________________

Birth weight?_____________________

Birth Hospital Name, City, State: ____ ____________________________

____

Diagnosis History:

Diagnosed with____

By (Name and Specialty of Physician)____

at child's age of ____________________________

Hospitalizations:____

Medications:____

Developmental History

Please tell the approximate age your child reached the following milestones:

_____________Rolled over ___________________ Sit unsupported ______________Creeping on all fours

_____________ Standing unsupported ________________Walking unsupported

Does your child have food preferences/aversions? Yes/No_________________

If yes, please explain:____

Current concerns for Physical Therapy intervention: ____

____

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PLEASE READ AND SIGN THE FOLLOWING

I give permission for Taylor Made Therapies, LLC and contracted therapists to evaluate and treat my child.

Signature____ Date________________________

I have reviewed and received Taylor Made Therapies LLC's HIPAA Policy Statement.

Signature____ Date_________________________

I authorize release of any medical or other information necessary to process this claim, including release of information to my Primary Care Physician as designated above and directly to the insurance company. I authorize payment of medical benefits to Taylor Made Therapies, LLC for services provided. I request and assign benefits to Taylor Made Therapies, LLC for all insurance benefits otherwise payable to me for services rendered.

Signature____ Date_________________________

I authorize discussion of my case with the following specific individuals:

____

____

____

____

____

Signature____ Date___________________________