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 consent to receiving email communication Yes No

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___________________________