HANDPRINTS & FOOTSTEPS

Patient History

Name of Child: ____ Date: _______________________

Date of Birth: ____

Parent(s)/Guardian: ____

Address: ________________________________ City: ________________ State: _____ Zip: ______________

Home Phone: ____________________ Father's Name/Work Phone: ____________________________________

Cell Phone: ______________________ Mother's Name/Work Phone: ____________________________________

Email Address: ____

Emergency Contact (other than parents) Name: _____________________ Number:______________________

Is it okay to leave a message at these phone #'s? Yes____ No____ If no, please specify: ________________

____

Diagnosis: ____

Allergies: ____

Other Medical Conditions/Diagnoses: ____

Referred By: ____

Parent Concerns: ____

____

____

Current/Previous OT/PT/SLP Program: ____

____

____

Primary Care Physician: _______________________________
Other Physicians: _______________________________
(Orthopod, Neurologist, _______________________________
Ophthalmologist, etc.) _______________________________
____

Medications: ____
Previous Surgeries: ____
____

Orthotics/Equipment: ____

*** Please fill out the back ***

Significant Birth History: ____
____
____
____
____

Method of Payment: ____

I authorize my insurance company to directly pay Handprints and Footsteps. I understand that I am responsible for any portion of payment not covered by insurance or other agency, and agree to pay this amount at the time of service.

Signature: ____ Date: ________________________________

I give consent for my child to undergo speech, occupational therapy, and/or physical therapy evaluations and participate in treatment outlined in therapist's plan of care.

Signature: ____ Date: ________________________________

I give consent for students and/or volunteers to observe and/or participate in the treatment of my child.

Signature: ____ Date: ________________________________