PATIENT REGISTRATION FORM
Wendell Foster's Outpatient Services

PATIENT NAME _____
(Last) (First) (MI) (SOC SEC #)
STREET OR BOX NO _____ **CITY** _____ **ST** _____ **ZIP** _____

COUNTY _____ ___ **FEMALE** ___**MALE** **RACE** _____ **BIRTH DATE** _____

DIAGNOSIS _____ **REFERRAL SOURCE** _____

****

___ **SPOUSE** ___ **PARENT INFORMATION (***If parent information, fill both name sections completely)

Responsible Party #1	**Responsible Party #2**
NAME _____	***NAME** _____
ADDRESS _____	***ADDRESS** _____
CITY _____ **ST**_____ **ZIP**_____	***** **CITY** _____ **ST**_____ **ZIP**_____
HM PH _____ **CELL** _____	***** **HM PH** _____ **CELL** _____
SOC SEC # _____ **BIRTH DATE**_____	***** **SOC SEC #** _____ **BIRTH DATE**_____
E-MAIL _____	***E-MAIL** _____
EMPLOYER _____	***** **EMPLOYER** _____
EMPL ADD _____ **PH**_____	***** **EMPL ADD** _____ **PH**_____

****

PRIMARY INSURANCE	**SECONDARY INSURANCE**
NAME OF INS_____	**NAME OF INS**_____
ADDRESS _____	**ADDRESS** _____
CITY _____**ST** ____ **ZIP**_____	**CITY** _____**ST** ____ **ZIP**_____
PHONE _____ **EFFECTIVE DATE** _____	**PHONE** _____ **EFFECTIVE DATE** _____
POLICY HOLDER NAME _____	**POLICY HOLDER NAME** _____
POLICY ID/GRP # _____	**POLICY ID/GRP #** _____

PRIMARY CARE PHYSICIAN & ADD _____

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ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL RESPONSIBILITY AGREEMENT: **I hereby authorize my signature on all insurance and Medicare claim forms at the office of Wendell Foster's Campus for payment directly to him/her for service rendered to me/patient. I authorize this office to make and send copies of medical records that may be needed to file my insurance claims. I understand that I/patient am responsible for charges incurred regardless of whether my insurance pays or not. I understand that if any unpaid balance is assigned to a third party collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of 33 1/3 % will be added to my account. I agree to pay that fee. I also agree to pay reasonable attorney fees and court costs. I understand and agree to the above terms.**

SIGNATURE _____ **DATE** _____

Wendell Foster
Empowering People With Disabilities

Comprehensive Outpatient Rehabilitation Facility
815 Triplett Street
P.O. Box 1668
Owensboro, KY 42302
(270) 689 - 1738

Thank you for scheduling an evaluation at Wendell Foster's Campus. Please complete the following information in order to provide our therapist with the most information possible. Please bring the completed form to the evaluation appointment.

Child's Name:_____ Birthdate:_____

Child likes to be called:_____

What language do you speak at home?_____

CONCERNS

Please list any concerns regarding your child. These concerns may or may not be therapy related and may include concerns in a variety of environments, including home, school, work, and community.

_____

_____

_____

_____

What would you like to see your child achieve through Wendell Foster's Outpatient Services?

_____

_____

_____

_____

Please list all persons living in the home including siblings and non-siblings.

Name	Age	Relationship

EDUCATION

If your child currently attends school, please complete the following:

Current grade:_____ Name of School:_____

Does your child receive therapy services at school? Yes ( ) No ( )

If yes, please list the services received, frequency, and therapist name if known.

Type of therapy	Frequency	Therapist Name
Physical Therapy ( )		
Occupational Therapy ( )		
Speech Therapy ( )		
Other ( )		

Does your child have an IEP? Yes ( ) No ( )

BIRTH HISTORY

Was your child born prematurely? Yes ( ) No ( ) If yes, born at _____ weeks

Birth weight? _____ Vaginal birth ( ) Cesarean birth ( )

Were there any complications prior to or at the time of birth? Yes ( ) No ( )

If yes, please describe:

Describe any complications at birth

	YES	NO	COMMENTS
Convulsions			
Cyanosis (Blue)			
Feeding			
Sucking / Swallowing			
Initiating breathing			Was he/she intubated?
Jaundice			
Stay in NICU			Length of stay:
Low birth weight			
Weight loss			
Incubation			
Physical malformation			

Did your child require any equipment to breath or eat after birth? Yes ( ) No ( )

If yes, please describe:

MEDICAL HISTORY

Does your child have any of the following?

Autism/PDD ( )	Cerebral Palsy ( )	Traumatic Brain Injury ( )
Spina Bifida ( )	Heart Disease ( )	Attention Deficit Disorder ( )
Seizure Disorder ( )	Developmental Delay ( )	Down Syndrome ( )

Other Diagnosis ( ) *Please list:*

Indicate if there are (past or current) any difficulties involving the following:

	YES	NO	AGE	COMMENTS
Swallowing Difficulties				Gagging ( ) Choking ( )
Difficulty Chewing				
Weight Loss / Unable to Gain weight				
Weight Gain / Overweight				
Feeding Issues				
Frequent Falls				
Reflux / Digestive Issues				
Difficulty Walking				
History of Fractures / Dislocations				
Frequent Ear Infections				
Tonsil / Adenoid Removal				
Vision Difficulties				
Hearing Difficulties				
Problems at School				
Difficulty with Attention Skills				
Cardiopulmonary Issues (Heart, Lung, Breathing, Asthma)				
Anemia				
Diabetes				
Endocrine Imbalance				
Diarrhea				
Constipation				
Other:				

Please list any surgeries or reoccurring illnesses (please include date of surgeries):

Allergies (ex. Food, Medicine, Environmental):

Current Medications:

Has your child ever had a seizure? Yes ( ) No ( )

Type of seizure:

Frequency of seizures:

What happens before your child has a seizure?

Please describe what your child's seizures look like:

What do you do when your child has a seizure?

If your child is seen by any of the following medical professionals, please complete the sections below:

Type of Professional	Name	Facility
Pediatrician		
Neurologist		
Optometrist		
Ophthalmologist		
Orthopedist		
Urologist		
Pulmonologist		
Genetics		
Gastroenterologist		
Psychologist		
Psychiatrist		
Other:		

THERAPY HISTORY

Did your child receive early intervention (i.e. First Steps) services? Yes ( ) No ( )

If yes, what services? OT ( ) PT ( ) ST ( )_ DI ( ) Other:_____

Has your child ever received outpatient therapy services? Yes ( ) No ( )_

If yes, what services? OT ( ) PT ( ) ST ( )_ DI ( ) Other:_____

Has your child ever received therapy services in school? Yes ( )_ No ( )

If yes, what services? OT ( ) PT ( ) ST ( )_ DI ( ) Other:_____

Does your child currently receive any outpatient therapy services? Yes ( ) No ( )
If yes, please list current providers:

Type of therapy	Therapist Name	Facility
Physical Therapy		
Occupational Therapy		
Speech Therapy		
Developmental Intervention		
Applied Behavioral Analysis		
Other:		

CURRENT FUNCTIONAL ABILITIES

Is your child able to complete the following activities, with or without help?

Activity	Can complete without help	Age child was able to complete without help	Needs help to complete	Does not participate in activity, even with help
Roll				
Crawl				
Sit				
Stand				
Walk				
Run				
Jump				
Kick a ball				
Throw a ball				
Ride a bike				
Get dressed				
Get undressed				
Toileting				
Brush teeth				
Wash hands				
Feed self with utensils				
Drink from cup				
Eat solid foods				
Cut with scissors				
Write name				
Write sentences				
Follow directions				
Spoke first word				
Tell you needs/wants				
Identify colors				
Identify shapes				
Identify letters				

Is your child right or left handed? _____ No preference? ( )

Does your child follow a special diet? Yes ( ) No ( )
If yes please describe:

Has your child ever had a swallow study? Yes ( ) No ( )
If yes, please list date and results:

Is your child a picky eater? Yes ( ) No ( )
What does your child prefer to eat or drink:

What is your child's primary means of mobility, or getting around?
Carried by adult ( ) Rolling ( ) Crawling ( ) Walking with help ( ) Walking alone ( )
Walking with equipment ( ) Wheelchair ( ) Stroller ( )

Does your child use any of the following adaptive equipment?
If yes, please explain:
( ) Wheelchair / Stroller
( ) Stander
( ) Braces / Splints
( ) Feeding Equipment
( ) Computer

COMMUNICATION

Does your child have problems with vision or hearing? Yes ( ) No ( )
If yes, please explain:

Does your child wear glasses? Yes ( ) No ( )
Does your child wear hearing aids? Yes ( ) No ( )

How does your child let your know what they want?
Pictures ( ) Gestures ( ) Signs ( ) Device ( ) Single Words ( ) Sentences ( )
Looks at it ( ) Other ( )

Does your child have special communication equipment (ex. book, device, or pictures) Yes ( ) No ( )
If yes, please describe:

Approximately how many single words does your child use? _____

How many words does your child use in a sentence? _____

Does your child understand more than they can say? Yes ( ) No ( )

How much of what your child says can you understand?
( ) Almost all 100% | ( ) Most of it 75% | ( ) About half 50% | ( ) Just a little 25% | ( ) Almost none 0%

How much of what your child says can other people understand?
( ) Almost all 100% | ( ) Most of it 75% | ( ) About half 50% | ( ) Just a little 25% | ( ) Almost none 0%

Does your child follow single step directions? Yes ( ) No ( )

Can your child follow multi-step directions? Yes ( ) No ( )

About how long can your child pay attention to a tabletop activity or listen to a book that is being read aloud?
_____ (minutes)

BEHAVIOR

Does your child have	Yes	No	Sometimes	Comments
Frequent meltdowns				
Aggressive behaviors				
Hurt him/herself				
Run away from you				
Do what is asked				
Fear of strangers				
Specific fear				
Difficulty changing from one activity to the other?				
Other:				

What are some of your child's favorite toys, games, characters, or activities?

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire. This information will help assist the therapist in completing the most effective evaluation possible.