

SENSORY SOLUTIONS, LLC

Physical, Speech, Occupational, Nutritional, and Behavioral Health Therapy for Children

Patient History Form

*Please fill out the questionnaire as accurately and completely as possible.

Child's Name: _____
Birth Date: _____ Person Completing this Form: _____
Referred by: _____
Diagnosis(es): _____
What are your concerns regarding your child? _____

Parent/ Guardian Name: _____
Address: _____
Zip Code: _____ Cell Phone: _____ Home Phone: _____
Email: _____
Education: _____ Occupation: _____
*Last 4 of SSN: _____ Work Phone: _____

Parent/ Guardian Name: _____
Address _____
Zip Code: _____ Cell Phone: _____ Home Phone: _____
Email: _____
Education: _____ Occupation: _____
Employer: _____ Work Phone: _____

Siblings (and ages): _____

Marital Status (Please check): Married Separated Divorced Widowed Single

Medical Insurance Company: _____
Whom will be responsible for payments: _____

Emergency contact information:
Name: _____ Relationship: _____
Phone Number: _____

Child's Pediatrician: _____
Address: _____
Zip Code: _____ Phone: _____ Fax: _____

Corporate Office

10332 Old Olive St. Rd.
Creve Coeur, MO 63141
314.567.4707 (Phone)
314.567.4505 (Fax)

St. Peters Location

4200 N. Cloverleaf Drive, Ste. J
St. Peters, MO 63376
636.922.4700 (Phone)
636.922.4505 (Fax)

North County Location

235 Dunn Road
Florissant, MO 63031
314.912.4707(Phone)
314.866.5849 (Fax)

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How long has your child been under this physician's care?: _____

MEDICAL HISTORY:

Pregnancy: ___ Full Term ___ Premature

Length of Gestation: _____

Mother's general health during pregnancy: ___ Good ___ Fair ___ Poor

Problems encountered during pregnancy (e.g., illnesses, injuries, stress, bleeding, fainting spells, anemia, etc.): _____

Length of total labor: _____

Difficult labor: ___ Yes ___ No

Delivery Type:

___ Vaginal

___ C-section

Child's birth weight: _____ lbs. _____ oz.

Complications:

___ Induced Birth

___ Breech Presentation

___ Limpness

___ Stiffness

Other: _____

Elaborate on above delivery complications: _____

Length of hospitalization: _____

Complications:

___ Jaundice

___ Cyanosis

___ Congenital defects

Other: _____

Was there a need for:

___ Oxygen

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Transfusions

Tube Feedings

If so, please explain: _____

Were there any feeding difficulties in infancy: Yes No

Explain: _____

Problems encountered during your child's first month: _____

List illnesses/diseases your child has experienced:

Illness: _____ Age: _____
Illness: _____ Age: _____
Illness: _____ Age: _____

List injuries/operations your child has had:

Injury/operation: _____ Age: _____
Injury/operation: _____ Age: _____
Injury/operation: _____ Age: _____

Has your child experienced high fevers: Yes No

Age: _____ Temp: _____ Frequency: _____

Has your child experienced convulsions/seizures: Yes No

Age: _____ Type: _____ Frequency: _____ Medication: _____

Has your child experienced ear infections: Yes No Frequency: _____

Has your child had tubes placed: Yes No When: _____

Date of last hearing evaluation: _____ Results: _____

Where was the hearing evaluation completed: _____

Date of last vision evaluation: _____ Results: _____

Where was the vision evaluation completed: _____

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Allergies:

- None
- Seasonal
- Food
- Other

Please list all allergies: _____

History of acid reflux: Yes No
If yes, when and how was it treated: _____

Child's general health at present:

- Good
- Fair
- Poor

Is your child currently taking any medications: Yes No
If yes, type(s): _____

SPECIALTY CONTACTS:

Specialty	Name of Agency/Specialist	Address	Phone
Audiologist	_____	_____	_____
Behavior Therapist	_____	_____	_____
Cardiologist	_____	_____	_____
Chiropractor	_____	_____	_____
ENT	_____	_____	_____
Occupational Therapist	_____	_____	_____
Ophthalmologist/ Optometrist	_____	_____	_____

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Orthopedist _____

Physical
Therapist _____

Psychologist/
Psychiatrist _____

Speech
Pathologist _____

Neurologist _____

GI _____

Other _____

DEVELOPMENTAL HISTORY:

Check which of the following describes/described your child as an infant:

- Fussy
- Irritable
- Good
- Quiet
- Passive
- Active
- Liked being held
- Resisted being held
- Floppy when held
- Tense muscles when held
- Good sleep patterns
- Irregular sleep patterns

Check which of the following describes your child at present:

- Usually happy
- Mostly quiet
- Overly active
- Tires easily
- Talks constantly
- Too impulsive
- Poor attention span
- Easily frustrated
- Cries often
- Cries infrequently
- Rocks self frequently
- Has difficulty learning new tasks

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- | | |
|--|---|
| <input type="checkbox"/> Restless | <input type="checkbox"/> Stubborn |
| <input type="checkbox"/> Resistant to changes | <input type="checkbox"/> Overreacts |
| <input type="checkbox"/> Clumsy | <input type="checkbox"/> Wets bed |
| <input type="checkbox"/> Fights frequently | <input type="checkbox"/> Frequent temper tantrums |
| <input type="checkbox"/> Difficulty separating from primary caretakers | <input type="checkbox"/> Nervous habits or tics |
| <input type="checkbox"/> Falls often | |

Approximate ages in which your child completed the following routinely:

Held up head (while on stomach): _____

Rolled over: _____

Belly crawled: _____

Crawled on hands and knees: _____

Sat independently: _____

Pulled to standing: _____

Standing independently: _____

Walking independently: _____

Babbling: _____ Were there a variety of sounds: _____

Producing single words: _____

Combining two words: _____

Obedying simple commands: _____

Does your child wear orthotics: Yes No Type: _____

Does your child require/use medical equipment: _____

Does your child use assistive devices for walking: Yes No Type: _____

General impressions of your child's motor development:

Gross Motor: Slow Normal Advanced

Fine Motor: Slow Normal Advanced

Handwriting: Poor Fair Good

Does your child show a hand preference with:

Feeding Which hand: _____

Writing/Drawing Which hand: _____

Throwing Which hand: _____

Pointing Which hand: _____

Cutting Which hand: _____

Has your child achieved skills and then lost them: Yes No

Explain (what and when): _____

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Has your child received prior therapy? (Please check all that apply):

First Steps School Outpatient facility similar to Sensory Solutions

FEEDING:

Bottle fed: Yes No Type of formula: _____

Nursed: Yes No

Currently eats:

- Breast milk
- Formula
- Baby food
- Junior foods
- Mashed table foods
- Table foods

Feeds self: All Most Some Rare

If feeds self, uses: Bottle Fingers Spoon Fork

Drinks from:

Bottle Sippy cup Soft straw Hard straw Open cup

List most preferred foods: _____

List avoided foods: _____

SELF-CARE:

Bathes self: All Most Some None

Undresses self: All Most Some None

Dresses self: All Most Some None

Is your child toilet trained: Yes No

If yes, at what age: _____

Bladder (daytime) Bladder (day and nighttime) Bowel

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SENSORY HISTORY:

VESTIBULAR (Movement and gravity information). Check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Rocks while sitting | <input type="checkbox"/> Jumps a lot |
| <input type="checkbox"/> Likes being tossed in the air | <input type="checkbox"/> Good balance |
| <input type="checkbox"/> Fearful of heights | <input type="checkbox"/> Fearful of movement |
| <input type="checkbox"/> Likes Merry-Go-Rounds | <input type="checkbox"/> Spins and Whirls more than others |
| <input type="checkbox"/> Gets car sick | <input type="checkbox"/> Prefers quiet play as opposed to active |
| <input type="checkbox"/> Enjoys being rocked: <input type="checkbox"/> Now <input type="checkbox"/> As an infant | |
| <input type="checkbox"/> No fear of movement or falling | |

Comments: _____

TACTILE (Touch information). Check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Avoids messy things (mud, finger paints, etc.) | <input type="checkbox"/> Dislikes face or hands washed |
| <input type="checkbox"/> Irritated by cloth of certain textures | <input type="checkbox"/> Objects to being touched |
| <input type="checkbox"/> Dislikes unexpected touch | <input type="checkbox"/> Avoids using hands for extended periods |
| <input type="checkbox"/> Bangs head on purpose (now or in past) | <input type="checkbox"/> Pinches, bites, hurts self |
| <input type="checkbox"/> Mouths non-food objects | <input type="checkbox"/> Feels pain less than others |
| <input type="checkbox"/> Isolates self from others | <input type="checkbox"/> Strong like/dislike toward food textures |
| <input type="checkbox"/> Excessively ticklish | <input type="checkbox"/> Dislikes hair washing |
| <input type="checkbox"/> Dislikes nail cutting | <input type="checkbox"/> Wants to handle everything |
| <input type="checkbox"/> Seeks a lot of touch | |

Comments: _____

PROPRIOCEPTIVE (Muscle and joint information). Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Holds hands in strange positions | <input type="checkbox"/> Holds body in strange positions |
| <input type="checkbox"/> Good coordination with small items | <input type="checkbox"/> Walks on toes (or did when younger) |
| <input type="checkbox"/> Went from sitting to standing with little to no crawling | |
| <input type="checkbox"/> Crept on tummy rather than hands and knees | |
| <input type="checkbox"/> Leaps from one position to the next, unable to move slowly from one place to another | |

Comments: _____

AUDITORY: (Check all that apply)

- | |
|---|
| <input type="checkbox"/> Responds negatively to unexpected or loud noise |
| <input type="checkbox"/> Has difficulty paying attention when there are other noises nearby |
| <input type="checkbox"/> Misses hearing some sounds |

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- Seems confused as to the direction of sounds
- Seems to enjoy strange noises and/or makes loud noises
- Appears to be hard of hearing
- Enjoys music
- Has a diagnosed hearing loss
- Wears a hearing aid

Comments: _____

VISUAL: (Check all that apply)

- Reversals in copying
- Looks very closely at pictures/objects
- Resists having eyes covered
- Becomes excited when there is a variety of visual objects
- Difficulty focusing on objects far away
- Wears glasses
- Difficulty following objects across the room
- Difficulty following object tossed to him/her
- Shifts head to one side in order to look at an object
- Happier in the dark
- Difficulty discriminating shapes or colors
- Squints often
- Difficulty focusing on close objects
- Difficulty maintaining eye contact
- Sometimes shakes head awkwardly

Comments: _____

GUSTATORY-OLFACTORY (Taste and smell information). Check all that apply:

- Acts as though all food tastes the same
- Has unusual cravings for certain foods
- Explores by smelling
- Reacts negatively to smell
- Chews on non-food objects
- Dislikes food of certain textures
- Discriminates odor
- Ignores unpleasant odors

Comments: _____

SPEECH-LANGUAGE HISTORY:

SPOKEN LANGUAGE (Expressive Language). Check all that apply:

- Makes no sounds or makes sounds on a limited basis
- Uses gestures more than words to communicate
- Babbles only
- No true words
- Uses sign language. If yes, what signs: _____
- Produces only single words or short phrases

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- Produces simple sentences
- Produces long sentences
- Produces long sentences which are disorganized or hard to understand what the child means
- Repeats words often or hesitates frequently
- Words are difficult to understand (articulation)
- Voice quality is unusual (e.g., hoarse, nasal, abnormally high pitched)
- Has difficulty recalling recent events
- Has trouble remembering the correct names of items or people
- Has no apparent problems expressing himself/herself
- Seems frustrated when attempting to relate events
- Stutters frequently

Approximately how many words does your child produce spontaneously: _____

Comments on any of the above: _____

COMPREHENSION (Receptive Language). Check all that apply:

- Does not understand spoken language
- Understands a few words
- Understands most words
- Understands simple conversations
- Understands everything said to him/her
- Follows simple commands
- Requires directions to be broken down in steps in order to follow
- Follows all directions easily

Comment on any of the above: _____

PRAGMATIC LANGUAGE (Social Skills). Check all that apply:

- Difficulty interacting with peers and/or adults
- Difficulty greeting/saying goodbye to others
- Difficulty with turn-taking
- Difficulty with maintaining conversations
- Makes frequent inappropriate remarks
- Difficulty making/maintaining eye contact

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Comment on any of the above: _____

ARTICULATION (Check all that apply):

- Speech sounds are not understood by others
- Speech sounds are understood by others some of the time
- Speech sounds are understood by others most of the time
- Speech sounds are understood by others all of the time

Comment on any of the above: _____

If applicable, how severe do you think your child's language and/or articulation is:

- Severe
- Moderate
- Mild

Is your child aware of the problem: Yes No

How does he/she react: _____

Is any language other than English used in the home: Yes No

If yes, what language(s): _____

What percent of the time: _____

SCHOOL INFORMATION:

School: _____ Grade: _____

School Days: Part day (AM/PM) All day

Teacher: _____

Grades Repeated: _____ Grades Skipped: _____

Has your child been in a special classroom and/or attended any remedial classes: Yes No

If yes, describe what type, when, and when: _____

Does your child have an IEP/IFSP: Yes No

If yes, please provide a copy to your therapist

Have you or the teacher observed that you child is (Check all that apply):

- Noticeably distracted in class
- Functions better in a one-to-one relationship rather than in classroom situations

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- Has to be reminded how to hold pencil/paper when writing
- Needs to prop his/her head in hand while reading or writing at the desk
- Confused in right-left discrimination tasks (describe): _____
- _____
- A poor speller

Which academic skills are the hardest: _____

If there are other concerns not covered in this form, please share: _____

Person completing this form: _____

Date: _____

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Policies & Procedures

- All co-pays and balances are due at the time of service and must be paid in full before your child will be seen by his/her therapist.
- Authorization is **not a guarantee of payment**. If your insurance company denies payment you will be responsible for the entire balance.
- Outstanding balances will be sent to collections and therapy will be discontinued.
- 24 hour **CANCELLATION NOTICE** is appreciated; otherwise, there will be a \$30 charge.
- **2 NO CALL/NO SHOWS** will forfeit your standing appointment time.
- **CANCELLATIONS** must be made up within the following week; otherwise, this will result in a forfeiture of your standing appointment time.
- Returned checks will result in a \$30 fee due at the time of notification.
- We are a **teaching facility**; therefore, there may be times when a student observes or runs the therapy session under the supervision of the treating therapist. You will be notified before the session begins if a student will be involved in the therapy session.
- Due to insurance liabilities we ask that you be seated in the waiting area until a therapist can lead your child to a treatment room for therapy.
- If you choose to bring siblings with you, please bring activities to keep them occupied as excessive volume may interrupt treatment sessions. Siblings are not allowed on therapy equipment at any time
- Please note that your therapist may advise you to step out of the therapy session or remain in the waiting room during the therapy session to ensure your child's optimal performance and to establish a trusting relationship and good rapport with your child.
- We do our very best to begin and end treatment sessions on time. Please be prompt for appointments as they end 30 minutes from the start of your scheduled appointment time. If you choose to drop off your child for therapy, please leave an emergency contact number at the front desk and return to the waiting room before your child's session is over.
- If your child is potty training or was recently potty trained, please bring extra diapers and a change of clothes.
- We reserve the right to discontinue therapy services if we feel our staff, other patients, and/or your child are at risk for injury or physical harm due to **aggressive behaviors** before, during, and/or after therapy sessions. When appropriate, we will offer a one-time warning before discontinuing services. Aggressive behaviors include, but are not limited to, hitting, kicking, biting, punching, shoving, hair pulling, inappropriate language, and destruction of property.
- Unless we are provided with legal documents stating otherwise, we are required by law to provide both parents with information regarding the child's therapy services, progress, etc.

By signing this document, I acknowledge that I have read and agree to everything listed in the above policy and procedures.

Signature _____ Date _____

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Release and Assumption of Risk

- o In Consideration of the services of Sensory Solutions, LLC, their agents, owners, officers, affiliates, volunteers, interns, participants, therapists, therapeutic assistants, employees and all other persons or entities acting in any capacity on their behalf, (hereinafter collectively referred to as “SSL”), I hereby agree to release, indemnify, and discharge SSL on behalf of myself, my spouse, my children, my parents, my heirs, assigns, personal representative and estate as follows:
- o I acknowledge that my participation in Sensory Solutions, LLC, programs, therapies, camps, retraining techniques, rehabilitation programs, games or activities entails known and unanticipated risks that could result in physical or emotional injury, paralysis, death, or damage to the patient, to property, or potentially to third parties. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the therapy and/or activity.
- If you or your child is injured, you or your child may require medical assistance, at your own expense.
 - o Furthermore, SSL therapists and employees have difficult jobs to perform. They seek safety, but they are not infallible. They might be completely unaware of a participant’s health or abilities. They may give incomplete warnings or instructions, and the equipment being used might malfunction.

The undersigned expressly agrees and promises to accept and assume all of the risks existing in these therapies and activities. My or my child’s participation in the program is purely voluntary, and I elect to participate or allow my child to participate in spite of the risks.

I hereby voluntarily release, forever discharge, and agree to indemnify and hold harmless SSL from any and all claims, demands, or causes of action, which are in any way connected with my participation in SSL activities or my use of SSL equipment or facilities, including any such claims which allege negligent acts or omissions of SSL.

Should SSL or anyone acting on their behalf, be required to incur attorney’s fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.

I certify that I have adequate insurance to cover any injury or damage my child may cause or suffer while participating, or else I agree to bear the costs of such injury or physical conditions I may have.

Any disagreements under this agreement shall be resolved in the County of St. Louis, State of Missouri. I agree that if any portion of this agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect.

By signing this document, I acknowledge that if anyone is hurt or property is damaged during my or my child’s participation in this activity, I may be found by a court of law to have waived my right to maintain a lawsuit against SSL on the basis of my claim from which I have released them herein. I have had sufficient opportunity to read this entire document. I have read and understood it, and I agree to be bound by its terms.

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Participant Name: _____

Parent Signature (if child is minor) _____

Date: _____

Address: _____

E-Mail: _____ Phone#: _____ DOB: _____

I would like to receive special offers, notices of events and updates from SENSORY SOLUTIONS, LLC, via email
_____ YES _____ NO

Please tell us how you heard about SENSORY SOLUTIONS: _____

EMERGENCY CONTACT: _____ Phone #: _____

Relationship to participant: _____

PARENT'S OR GUARDIAN'S ADDITIONAL IDENTIFICATION (Must be completed for participants under the age of 18)

In consideration of _____ (print minor's name) ("Minor") being permitted by SSL to participate in its therapies and activities and to use its equipment and facilities, I further agree to indemnify and hold harmless SSL from any and all claims which are brought by, or on behalf of Minor, and which are in any way connected with such use or participation by Minor.

Parent or Guardian Signature: _____

Print Name: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form is being provided to acknowledge your receipt of our Notice of Privacy Practices.

What is the Notice of Privacy Practices?

The Notice of Privacy Practices explains how your patient health information may be used or disclosed by us. In addition, it explains your rights with regard to your patient health information, as well as our legal responsibilities.

Acknowledgement of Receipt

By signing below, you are acknowledging that the Notice of Privacy Practices has been provided to you:

I, _____ (Print Patient's Name)

Residing at _____ (Print Patient's Address)

have received the Notice of Privacy Practices from Sensory Solutions LLC.

Signature/relationship

Date

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636.922.4700 (Phone)
636.922.4505 (Fax)

North County Location

235 Dunn Road
Florissant, MO 63031
314.912.4707(Phone)
314.866.5849 (Fax)

SENSORY SOLUTIONS, LLC

Physical, Speech, Occupational, Nutritional, and Behavioral Health Therapy for Children

PATIENT AGREEMENT

Assignment of Insurance Benefits

I authorize and direct that any insurance (major medical, Medicaid, Medicare or any other) proceeds payable for products or services provided to patient by Sensory Solutions, LLC be paid directly to Sensory Solutions, and hereby assign to Sensory Solutions, without recourse, all interest and rights to claim, collect, and receive, said proceeds from any insurance company providing coverage for these products and services. I authorize any and all insurance companies to furnish to Sensory Solutions, or its agent, any and all information pertaining to the patient's insurance benefits and the status of claims submitted by Sensory Solutions.

Financial Responsibility

Some or all of the services or products provided to patients by Sensory Solutions may be covered by insurance. Sensory Solutions has no responsibility for but at my request will attempt to assist in determining whether such coverage exists. If patient's insurance does not cover the products or services, or if patient's insurance carrier shall for any reason fail to pay, I acknowledge that patient is financially responsible for, and I agree to timely pay Sensory Solutions all charges for products and services provided to patient, plus attorney's fees and expenses incurred by Sensory Solutions in the collection of such charges. This obligation is binding upon my estate and my executors and administrators.

Agreement and Consent for Sensory Solutions Products and Services

Patient's Name ("Patient"): _____
Street Address: _____ Apt. #: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Last 4 of SSN: _____
Patient's Signature: _____

IF PATIENT IS A MINOR

I certify that I am duly authorized by Patient to act as Patient's personal representative and agent to execute this Agreement form on behalf of the Patient, and that my signature will bind the undersigned as parent or guardian of the Patient to the above-stated terms. I recognize that Sensory Solutions will provide products and services to patients in reliance upon this statement.

Printed or Typed Name of Parent or Legal Guardian: _____
Relationship to Patient: _____ Date: _____
Street Address if Different than Patient: _____
Signature of Parent or Legal Guardian: _____

I have read and understood the above information. I understand that I am responsible for any amount not covered by my insurance. Upon notification that my insurance will not cover all or part of the fees, I hereby authorize Sensory Solutions to charge the following credit card the total fees due:

Corporate Office

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Creve Coeur, MO 63141
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VISA/MASTERCARD/DISCOVER/AMEX (**REQUIRED**)

For your security, once entered, card numbers can no longer be accessed. You will only be charged the amount discussed. All charges send an automatic email receipt.

Card#: _____ Expiration Date: _____ CVV: _____
Cardholder Name: _____ Signature: _____
Name of Patient: _____

Confidentiality Policy

At Sensory Solutions, LLC we are committed to maintaining client confidentiality. However, due to space constraints, we are unable to meet with each of our clients' families in a private area at the end of each session. Therefore, we use the waiting area to provide you with information about your child's therapy session and home recommendations. We understand that you may prefer an alternative arrangement. If so, please let us know and we will accommodate you. If you prefer, you can schedule a meeting or phone consultation with your child's therapist every 1-2 months in place of one of your child's sessions or in addition to his/her session. Please understand that the visit will be billed privately to the family, not billed through insurance.

Child's name: _____

Parent's name: _____

___ I DO give permission for my child's therapist at Sensory Solutions, LLC to discuss and share verbal and/or written information about my child in the public waiting room at the end of each session.

___ I DO NOT give permission for my child's therapist at Sensory Solutions, LLC to discuss and share verbal and/or written information about my child in the public waiting room at the end of each session. I will schedule a meeting or phone consultation with my child's therapist every 1-2 months to discuss my child's therapy sessions. I understand that I will be billed for this meeting and that I may schedule this in lieu of a session. This will be billed as a private visit, not as an insurance visit.

Parent Signature: _____

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