Sensory Solutions, LLC

Physical, Speech, Occupational, and Nutritional 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 and relationship:_____
Referred by:_____
Diagnosis(es) (i.e., Autism, Down syndrome, ADHD, etc.)_____
_____
What are your concerns regarding your child?_____
_____
_____

Parent/Guardian Name:_____
Relationship to Child:☐Biological ☐Foster ☐Adoptive ☐Other:_____
Address:_____
Zip Code:_____ Cell Phone:_____ Home Phone:_____
Email:_____
Education:_____ Occupation:_____
Employer:_____ Work Phone:_____

Parent/Guardian Name:_____
Relationship to Child:☐Biological ☐Foster ☐Adoptive ☐Other:_____
Address_____
Zip Code:_____ Cell Phone:_____ Home Phone:_____
Email:_____
Education:_____ Occupation:_____
Employer:_____ Work Phone:_____

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

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

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

Corporate Office
10332 Old Olive St. Rd.
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Is any language other than English used in the home: ☐ Yes ☐ No
If yes, what language(s):_____

MEDICAL HISTORY:

Pregnancy: ☐ Full Term ☐ Premature
Length of Pregnancy:_____(weeks or months)

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

Length of total labor:_____

Labor/Delivery Complications:
☐ Induced Birth
☐ Breech Presentation
☐ Limpness
☐ Stiffness
☐ Other:_____
Elaborate on above labor/delivery complications:_____
_____
_____
_____

Delivery Type:
☐ Vaginal
☐ C-section

Complications following birth regarding child:
☐ Jaundice
☐ Cyanosis
☐ Congenital defects
☐ Other (please specify):_____

Length of hospitalization:_____ Child's birth weight: _____lbs. _____oz

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Did your baby require any of the following:

☐ Oxygen How long:_____

☐ Transfusions Type(s):_____

☐ Tube Feedings Type(s) and how long:_____

Other (please specify):_____

_____

Were there any feeding difficulties at birth: ☐ Yes ☐ No

Please specify feeding difficulties at birth: :_____

_____

List illnesses/diseases/injuries/operations your child has experienced:

Illness:_____ Age:_____

Illness:_____ Age:_____

Illness:_____ Age:_____

Injury/operation:_____ Age:_____

Injury/operation:_____ Age:_____

Injury/operation:_____ Age:_____

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:_____

Allergies:

☐ None

☐ Seasonal

☐ Food

☐ Other

Please list all allergies:_____

_____

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

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

SPECIALTY SERVICES YOUR CHILD RECEIVES:

☐ Audiologist	☐ Behavior Therapist	☐ Cardiologist	☐ Chiropractor
☐ Dietitian	☐ ENT	☐ Neurologist	☐ Occupational Therapist
☐ Ophthalmologist	☐ Optometrist	☐ Orthopedist	☐ Physical Therapist
☐ Psychologist	☐ Psychiatrist	☐ Speech Pathologist	☐ GI

☐ Other (please specify):_____

DEVELOPMENTAL HISTORY:

Developmental Milestones:
Approximate ages in which your child completed the following routinely:
Held up head (while on stomach):_____
Rolled over:_____
Sat independently:_____
Belly crawled:_____
Crawled on hands and knees:_____
Pulled to standing:_____
Standing independently:_____
Walking independently:_____
Babbling:_____ Were there a variety of sounds:_____
Producing single words:_____
Combining two words:_____
Obeying simple commands:_____

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

☐ Fussy	☐ Liked being held
☐ Irritable	☐ Resisted being held
☐ Good	☐ Floppy when held
☐ Quiet	☐ Tense muscles when held

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☐ Passive
☐ Active

☐ 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
☐ Restless
☐ Resistant to changes
☐ Clumsy
☐ Fights frequently
☐ Difficulty separating from primary caretakers
☐ Falls often

☐ Poor attention span
☐ Easily frustrated
☐ Cries often
☐ Cries infrequently
☐ Rocks self frequently
☐ Has difficulty learning new tasks
☐ Stubborn
☐ Overreacts
☐ Wets bed
☐ Frequent temper tantrums
☐ Nervous habits or tics

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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FEEDING:

Is your child a selective/picky eater: ☐ Yes ☐ No

Is your child able to use utensils independently: ☐ Yes ☐ No

SELF-CARE:

Bathes self: ☐ Independently ☐ Needs Assistance

Undresses self: ☐ Independently ☐ Needs Assistance

Dresses self: ☐ Independently ☐ Needs Assistance

Is your child toilet trained: ☐ Yes ☐ No

If yes, at what age:_____

☐ Bladder (daytime) ☐ Bladder (day and nighttime) ☐ Bowel

SENSORY HISTORY:

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

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

Comments:_____

TACTILE (Touch information). Check all that apply:

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

Comments:_____

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

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

Comments:_____

_____

AUDITORY: (Check all that apply)

- ☐ Responds negatively to unexpected or loud noise
- ☐ Has difficulty paying attention when there are other noises nearby
- ☐ Misses hearing some sounds
- ☐ 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
- ☐ Happier in the dark
- ☐ Looks very closely at pictures/objects
- ☐ Difficulty discriminating shapes or colors
- ☐ Resists having eyes covered
- ☐ Squints often
- ☐ Becomes excited when there is a variety of visual objects
- ☐ Difficulty focusing on objects far away
- ☐ Difficulty focusing on close objects
- ☐ Wears glasses
- ☐ Difficulty maintaining eye contact
- ☐ Difficulty following objects across the room
- ☐ Sometimes shakes head awkwardly
- ☐ Difficulty following object tossed to him/her
- ☐ Shifts head to one side in order to look at an object

Comments:_____

_____

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

- ☐ Acts as though all food tastes the same
- ☐ Chews on non-food objects
- ☐ Has unusual cravings for certain foods
- ☐ Dislikes food of certain textures

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☐ Explores by smelling ☐ Discriminates odor
☐ Reacts negatively to smell ☐ Ignores unpleasant odors
Comments: _____
_____

SPEECH-LANGUAGE HISTORYCONCERNS (CHECK ALL THAT APPLY):
☐ Spoken Language/Expressive Language
☐ Comprehension/Receptive Language
☐ Articulation/Speech Sound Production
☐ Stuttering
☐ Social Skills
Other (please specify): _____
_____

SCHOOL/DAYCARE/THERAPY INFORMATION:
Does your child attend school/daycare: ☐ Yes ☐ No
School/Daycare: _____ Grade: _____
School/Daycare Days: ☐ Part day (AM/PM) ☐ All day
Teacher: _____
Has the teacher expressed any concerns ☐ Yes ☐ No
(If yes, please specify): _____
_____

Has your child received prior therapy? (Please check all that apply):
☐ First Steps ☐ School ☐ Outpatient facility similar to Sensory Solutions

Does your child have an IEP/IFSP/504 Plan: ☐ Yes ☐ No
If yes, please provide a copy to your therapist

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 $50 charge per service your child receives
- If you are scheduled for an evaluation for one discipline, the cancellation/no call no show fee is $75
- If you are scheduled for a team evaluation (Feeding Team, AAC, ADOS), the fee will be $50 per discipline. The Feeding Team fee will be $150 and the AAC and ADOS team evaluations will be $100 if cancellations/no call no shows occur
- 2 **NO CALL/NO SHOWS** will forfeit your standing appointment time
- 2 **CANCELLATIONS** must be made up within the following 2 weeks; otherwise, this will result in a forfeiture of your standing appointment time
- Returned checks will result in a $25 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 25 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.

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- 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_____

Release and Assumption of Risk

- 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:
- 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.
  - 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 it terms.

Participant Name:_____
Parent/Guardian Signature (if child is minor)_____
Date:_____

Sensory Solutions, LLC

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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:_____

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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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 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 patient 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: _____

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 Patient 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 understand 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:

VISA/MASTERCARD/DISCOVER/AMEX (Circle one)

Card#_____ Expiration date_____

Cardholder name_____ Signature_____

Name of patient_____

Address:_____

Home #:_____Cell#:_____

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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 consult with your child's therapist every 1-2 months in place of one of your child's session 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 consult 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:_____

Toileting Permission Form

I (parent / guardian) _____ give permission for the staff of Sensory Solutions, LLC to assist _____ (my child) with their toileting needs if they are not self-reliant and/or an accident occurs. Toileting supplies such as diapers and wipes may be provided to my child in an emergency. I will provide supplies if my child has any special supplies.

☐ I understand the consent form above and give my permission for my child to be assisted in the bathroom if necessary. In the event the necessary supplies are not available, I will be called to bring supplies and/or pick up my child.

☐ I DO NOT give permission for Sensory Solutions staff to assist my child in toileting. I understand if my child soils them self, I will be called, and it will be my responsibility to come to the clinic immediately to tend to my child.

_____ _____

Print name of parent/guardian Relationship to child

_____ _____

Signature of parent/guardian Date

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Activities of Daily Living (ADLs) Parent Authorization

I (parent / guardian)_____ give permission for the staff of Sensory Solutions, LLC to assist _____ (my child) with dressing/undressing if this is a goal of my child's. Dressing and undressing may pertain to, but are not limited to, taking off shirts and/or pants as well as putting on shirts and/or pants. Please note that underwear will not be removed, unless working on toileting and the "Toileting Permission Form" has been signed.

☐ I DO understand the consent form above and give my permission for my child to work on dressing and undressing in any manner related to the goals my child's therapist has developed for my child

☐ I DO NOT give permission for Sensory Solutions' staff to work on dressing and undressing in any manner related to the goals my child's therapist has developed for my child (**Please note, this may limit the goals your child's therapist is allowed to address)

_____ _____

Print name of parent/guardian Relationship to child

_____ _____

Signature of parent/guardian Date

Media Release Form

At times, Sensory Solutions, LLC uses various forms of media for advertising purposes allowing members of the community to be made aware of the services Sensory Solutions, LLC provide. We also use photographs and videos to assist with public relations.

We request your permission to use pictures/videos of your child in any form of media we deem necessary to promote Sensory Solutions, LLC. We assure you that any form of media used in reference to your child will be in good taste while maintaining the respect and dignity of your child and their relationship with Sensory Solutions, LLC.

Please sign and date this form to allow or reject your consent for Sensory Solutions, LLC to use all forms of media of your child for advertising purposes.

I, _____ (parent/guardian name) DO GIVE permission to Sensory Solutions, LLC to use photographs and other media involving my child for public relations and advertising activities.

I, _____ (parent/guardian name) DO NOT give permission to Sensory Solutions, LLC to use photographs and other media involving my child for public relations and advertising activities.

Parent/Legal Guardian Printed Name:_____

Signature:_____ Date:_____

Corporate Office
10332 Old Olive St. Rd.
Creve Coeur, MO 63141
314.567.4707
fax 314.567.4505

St. Peters Location
4200 N Cloverleaf Drive, Suite J
St. Peters, MO 63376
636.922.4700
fax 636.922.4505

Florissant Location
235 Dunn Rd
Florissant, MO 63031
314.912.4704
fax 314.866.5849

sensorysolutions.com

Sensory Solutions, LLC

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

Custody/Release of Information

Patient name:_____DOB:_____
The following individual(s) have current custody of the above child:
_____
I, _____, give Sensory Solutions, LLC permission to disclose information to the following parties regarding patient care:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Please specify:

- ☐ Test results via verbal communication and/or email
- ☐ Progress toward goals via verbal communication and/or email
- ☐ Written reports which includes patient's doctor, primary caregiver, and home address
- ☐ All of the above

***Please provide Sensory Solutions, LLC with a copy of legal documentation regarding custody arrangements.**

Signature of primary caregiver: _____ Date: _____

Cancelation/No Call-No Show Policy

Our fee for cancellations and no call/no shows to $50 per session/discipline missed. If you fail to call within 24 hours, you will be charged the appropriate fee. For example, if you do not show up for both your speech therapy and occupational therapy sessions, you will be charged $100 for the services missed.

We do understand there are certain circumstances which may arise, including sudden sickness, etc., and we do take that into account and consideration before charges are made. We thank you for your understanding.

By signing below, you are acknowledging receipt of this policy.

_____ _____
Parent's/Guardian's Printed Name Parent's/Guardian's Signature

_____
Date

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