



SPORTS & WELLNESS
PHYSICAL THERAPY

PEDIATRICS PATIENT INFORMATION AND CONSENT FORM - OT

Name: _____ Circle: M/F Date: _____
Last First MI

Birthdate: _____ Age: _____

Parent/Guardian Name: _____ Relationship to Patient: _____

Parent/Guardian Name: _____ Relationship to Patient: _____

Address: _____
Street City State Zip

E-Mail Address: _____

Your email address will be used for appointment reminders. Check here if you prefer reminders via automated phone call or text

It may also be used to send periodical newsletters and information about upcoming events. Check here to opt out

Phone: Home _____ Work: _____ Cell: _____

Emergency Contact Person: _____
Name Relation Phone

RESPONSIBLE PARTY EMPLOYMENT INFORMATION

Name of Responsible Party: _____ Relation to Patient: _____

DOB: _____

Employer: _____ Job Title: _____

Address: _____
Street City State Zip

Phone: Home _____ Work: _____ Cell: _____

INSURANCE

TYPE: Private _____ Medicare _____ Auto _____ Worker's Comp _____ Other _____
(check) Specify

Primary Insurance Company: _____

Address: _____ Phone: _____

Agent/Adjuster: _____

Policy #: _____ Group #: _____

Insured's Name (if different from patient): _____

Secondary Insurance Company: _____

Address: _____ Phone: _____

Policy #: _____ Insured's Name: _____

PHYSICIAN

Name of Referring Physician: _____

Name of Family Doctor (if different): _____

Reason for Occupational Therapy: _____ Is therapy due to a car accident? Yes No

Date of Injury (please list-approx.ok): _____ Any Previous PT for Current Problems? Yes No

What other treatments have been tried? The outcome? _____

HISTORY

Do you now have/or have you had any of the following:

High Blood Pressure	YES	NO	Sensitive to Heat/Ice	YES	NO
Heart Disease	YES	NO	Allergies	YES	NO
Heart Attack	YES	NO	Hernia	YES	NO
Pacemaker	YES	NO	Seizures	YES	NO
Diabetes	YES	NO	Metal Implants	YES	NO
Headaches	YES	NO	Dizzy Spells	YES	NO
Kidney Problems	YES	NO	Balance Problems	YES	NO
Nervous Disorder	YES	NO	Vision Problems	YES	NO
Hearing Problems	YES	NO	Cancer	YES	NO
Speech Problems	YES	NO	Prior Hospitalizations	YES	NO

If YES on any of the above, please explain and give approximate dates _____

Are you presently taking any medication? List _____

List any other areas of concern: _____

Do you have difficulty with any of the following activities (check all that apply; if checked, please be specific. i.e. time limits, distance, weights, etc.)

Sitting _____	Sleeping _____
Standing _____	Personal Care _____
Walking _____	Lifting _____
Driving _____	Other _____

List any past surgeries and date of surgeries: _____

What benefits do you expect to gain from occupational therapy? Be specific:

- A. _____
- B. _____
- C. _____

The above information is correct to the best of my knowledge.

I have read and fully understand Sports & Wellness Physical Therapy’s Notice of Information Practices. I understand that Sports & Wellness Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Sports & Wellness Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Sports & Wellness Physical Therapy’s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I hereby authorize my insurance company to pay directly to Sports & Wellness Physical Therapy medical benefits otherwise payable to me, and I will be responsible to Sports & Wellness Physical Therapy for all expenses incidental to treatment rendered not paid under this plan.

Signature: _____ Date: _____
(If under 18, signature of parent or legal guardian)