Whitefish Therapy & Sport Center

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____ SSN _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____

First Name _____ Phone _____

Employer

Name _____ Phone _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit / /

Referred By _____ Primary Care Physician _____

Latest Referral Information _____ Motor Vehicle Accident _____

Latest Plan of Care _____ That occurred in: _____

Notes: _____

Primary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. Contact Ashley McGuire @ 406-862-9378.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ Date: _____

WHITEFISH THERAPY & SPORT CENTER

CHILD CASE HISTORY FORM: SPEECH, PHYSICAL, OCCUPATIONAL

Child's Name: _____**Date of birth**: _____

Person filling out this form: _____

Relationship to child: Mother Father Other: _____

Would you like to receive a text or email reminder of appointments?

☐ Yes ☐ No

If yes, please provide cell phone number with cell phone provider or email address:

_____

Child lives with (check all that apply):

☐ Parents ☐ Foster parent(s)

☐ Split time with parents ☐ Grandparent(s)

☐ Single parent ☐ Other _____

Please list siblings living in child's home:

Name:_____Age:_____ Name:_____Age:_____

Name:_____Age:_____ Name:_____Age:_____

If English is not your primary language, please list other language(s): _____

Please indicate your present concerns:

_____

PRENATAL/BIRTH HISTORY

Mother's illnesses, accidents, or infections during pregnancy:

_____

_____

Length of Pregnancy _____ Length of Labor_____

Time Spent in NICU (Neonatal Intensive Care Unit) _____

Any complications at delivery?

_____

_____

Did the child experience any of the following conditions immediately following birth?

- ☐ Breathing Difficulties
- ☐ Jaundice
- ☐ Bleeding
- ☐ Oxygen Needed
- ☐ Seizures
- ☐ Infections
- ☐ Feeding Problems
- ☐ Sucking/Swallowing Problems
- ☐ Other: _____

MEDICAL HISTORY: please check all that apply. Please provide the dates where applicable

- ☐ High Fever
- ☐ Ear Infections
- ☐ Seizures
- ☐ Asthma
- ☐ Frequent Colds
- ☐ Allergies
- ☐ Head Injuries
- ☐ Other Injuries
- ☐ Hospitalizations
- ☐ Illnesses
- ☐ Operations
- ☐ Diagnosed with ADHD/ADD
- ☐ Eating or swallowing problems
- ☐ Wears Glasses
- ☐ Hearing Problems
- ☐ Wears a Hearing Aid
- ☐ Behavioral Problems
- ☐ Other Diagnoses: _____ _____

Please explain the items checked:

_____

_____

_____

Medications: Please list child's current medications or attach list to be scanned, including: over the counter medications, vitamins/mineral/dietary supplements, prescription medications and any herbal supplements:

	Name of Medication	**Dosage**	**Frequency**	**Route of Administration (e.g., oral, IV, etc)**
1				
2				
3				
4				
5				

MOTOR AND SOCIAL DEVELOPMENT

At what age did the following first occur?

Rolling over: _____ Sitting up: _____ Eating solids: _____

Standing: _____ Taking steps: _____ First words: _____

Please check if your child is able to do the following:

☐ Use utensils ☐ Drink from an open cup ☐ Tie shoes

☐ Fasten buttons ☐ Dress him/herself

Does your child experience difficulty with bathing or grooming skills? If so, which ones?

_____

_____

Do you have concerns regarding your child's behavior?

_____

_____

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SPEECH-LANGUAGE HISTORY
Describe the child's communication at the present time. (Please check all that apply).

- ☐ Grunts and points
- ☐ Screams
- ☐ Gestures
- ☐ Takes you to object
- ☐ Copies what you do
- ☐ Copies what you say
- ☐ Follows directions
- ☐ Single words
- ☐ Two-word phrases
- ☐ Longer phrases/sentences
- ☐ Unclear speech
- ☐ Stuttering
- ☐ Too soft
- ☐ Too loud
- ☐ Hoarse

EDUCATIONAL HISTORY

School/Daycare: _____

Grade/Teacher: _____

Is your child currently receiving therapy (school, home, etc)? ☐ Yes ☐ No

If so, what type and what days? _____

Has your child received therapy in the past? ☐ Yes ☐ No

If so, what type and for how long? _____

_____

What are your goals for therapy?

_____

_____

What are some of your child's favorite toys and/or characters?

_____

_____

Please provide other information you believe to be helpful in the development of your child's care here with us at Whitefish Therapy and Sport Center. Thank you.

_____

_____

_____

By signing, you consent to therapy services provided by Whitefish Therapy & Sport Center.

This may include physical therapy, training services, occupational therapy, and/or speech therapy.

Services may entail the use of modalities such as therapeutic Ultrasound, E-stim, TENS, & Dry Needling. Your therapist(s) will discuss the rationale for use and will obtain verbal consent prior to treatment.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

Do you have any implants? YES or NO

If YES, what type? Medical Cosmetic

Do you have any blood borne pathogens? (HIV, Hepatitis, etc.) **YES** or **NO**

If YES, please list.

Would you like to receive appointment reminders the day before your appt? **YES** or **NO**

If YES, choose one: **TEXT** **EMAIL**

If TEXT requested, who is your cell service provider? (i.e. Verizon, AT&T, Cricket, etc)

_____

If EMAIL requested, please provide email address here:

_____

IF PATIENT IS A MINOR

Guardian's Name: _____

Mailing Address: _____

City _____ State _____ ZIP _____

Phone: _____

IF INSURANCE IS IN GUARDIAN'S NAME, PLEASE PROVIDE THE FOLLOWING:

DOB: _____

Social Security Number: _____

Additional Guardian's Name: _____

Mailing Address: _____

City _____ State _____ ZIP _____

Phone: _____

GUARANTOR Name - If different from above

_____

DOB: _____

Social Security Number: _____

Guardian's Printed Name: _____

Guardian's Signature: _____

DATE signed: _____