1300 McGee Drive, Suite 113 Norman, OK | Ph. (405) 366-7898 Fax (405) 366-0010 | www.TheraFUNction.com

NEW CLIENT QUESTIONNAIRE

Person completing form: _____ Today's Date: _____

Child's Name: _____Date of Birth: _____ M_____ F_____

Address: _____City:_____State:_____

Zip Code: _____Email:_____

Primary Phone (indicate name): _____ Cell? Y N

Alternate Phone (indicate name) _____ Cell? Y N

Work/Emergency Number (indicate name) _____

How did you hear about us? _____

Referred by: _____Phone#:_____

Primary Care Physician: _____ Physicians#:_____

Reason for Referral? _____

Known Diagnosis: _____

What therapy is your child currently receiving? OT / Speech / Physical Therapy / Counselor

With whom? _____How long? _____

Have you had an OT/Speech evaluation within the past 12 months? Yes / No -Therapist/Clinic:_____

What service(s) has your child had in the past?_____

With whom? _____Child's Age(s) of service?_____

FAMILY COMPOSITION:

Father's Name: _____
Relationship to Child: Biological Adoptive Step Foster Other

Father's Employer: _____

Mother's Name:_____
Relationship to Child: Biological Adoptive Step Foster Other

Mother's Employer: _____

Other Caregivers: _____

Child lives with:
Mom____Dad____Grandparents____Step Mom____Step Dad____Foster Parent____Adopted Parents____

Names and ages of siblings residing in and out of the home: _____
_____
_____

Primary Language Spoken in the Home: _____
Other Languages Spoken in the Home: _____

EDUCATION:

School/Preschool:_____ Grade _____

Hours in regular education? _____ Hours in special education? _____

Does the teacher/caregiver express any concerns? Y / N
If yes, describe:_____
Does your child receive therapy at school or with someone else? Y / N
Who:_____Where:_____
Can we contact them about your child's therapy? Y / N

Is your child on an IEP? Y / N (If yes, please provide a copy of the IEP)

What services do they get in the school? OT ST PT

Any previous professional help/evaluations? Y N If yes, who? _____ When? _____

BIRTH HISTORY:

Complications During Pregnancy (If yes, please explain):_____

_____

Complications During Labor (If yes, please explain):_____
_____

Gestational age at time of birth (or # weeks early or late):_____ Birth Weight:_____

Was labor induced? Y / N What was the purpose:_____

What type of birth/presentation? Vaginal / Cesarean

Was your child in the NICU? Y / N Duration:_____

Describe your baby in the first year of life (i.e. happy, slept all the time)_____
_____
_____

Were there any difficulties with nursing or taking a bottle?_____

Were there any difficulties with transition in food textures?_____

How well did your baby tolerate being on his/her stomach?

Not at all Sometimes Most of the time All the time

Please mention any pertinent information that was not covered above:_____
_____
_____

MEDICAL HISTORY:

Has your child had any (please describe) hospitalizations, surgeries?
_____
Major illnesses?_____

Has your child had any of the following (indicate age and duration):

	Age Effected	Duration
Allergies		
Asthma		
Constipation		
Diarrhea		
Ear infections		
Eye problems		
Headaches		
Stomach aches		
Reactions to vaccinations		

List other relevant medical issues:_____
_____

Is your child currently on any medications? Y / N

Name of Medication	Reason for Medication	Is it working?

Any known side effects to the medications:_____

Last eye exam:_____Pass?_____Fail?_____ Who completed? _____

Last hearing exam:_____Pass?_____Fail?_____ Who completed? _____

DEVELOPMENTAL MILESTONES:

Please complete the following that best describes the development of your child. If possible, describe changes of loss in skills by estimating the date or child's age at that time. Was there an event that coincided with the loss? Shots, trauma, illness etc._____?

MOTOR	AGE ACHIEVED	AGE LOST
Smiled		
Held head up		
Rolled over		
Reached for an object actively		
Transferred object between hands		
Sat unsupported		
Crawled (how)		
Stood alone		
Walked by self		
Ran by self		

SPEECH	AGE ACHIEVED	AGE LOST
Followed simple one step directions		
Said first words		
Said 2-3 word phrases		
Talks in sentences		
Knew colors		
Counted to five		
Knew alphabet		
Acknowledges/ recognizes name		

ACTIVITIES OF DAILY LIVING	AGE ACHIEVED	AGE LOST
Ate unaided with a spoon/ fork		
Dressed self		
Caught a thrown object		
Rode bicycle without training wheels		
Demonstrated handedness		
Bladder trained – days		
Bladder trained - nights		
Bowel trained		

ACTIVITIES OF DAILY LIVING:

FEEDING:
Does your child use a spoon_____fork_____knife_____

Bottle_____Sippy cup_____open cup_____straw_____

Does your child hold utensils correctly?_____Does your child prefer to finger feed?_____

Describe your child's eating habits and any concerns you have regarding feeding. Is your child a picky eater? Difficulty staying seated for meals, etc?_____
_____
_____

DRESSING:
Does your child dress independently?_____Undress?_____

Answer the following with the appropriate level of assistance needed from:
I=independent, Max=you do 70% of task, Mod=you do 50% of task, Min=you do 25% of task, and Total= You do 100% of task.

Overhead Shirt_____Front-opening garment_____Pants_____Socks_____
Shoes_____Buttons_____Zippers_____Snaps_____ Shoelaces_____

Buckles_____

Please describe how your child gets dressed (takes a long time, needs frequent reminders, tolerates limited fabrics, bothered by tags/socks/shoes, etc.):_____
_____
_____

BATHING/GROOMING:
Describe how your child tolerates bathing and their behavior during. (loves/hates it, afraid to tip head back to wash hair, etc.) How does your child handle washing/brushing hair, teeth and cutting nails? Do they require more assistance than you would anticipate for their age?_____
_____
_____

TOILETING:
Is your child aware of toileting needs? independent with toileting? Toileting hygiene?_____
_____

Does your child have good daytime/nighttime bladder control?_____
ORGANIZATION:
If applicable to age, is your child able to keep track of their belongings? Do they lose things more frequently than you would expect? Are they able to multi-task? _____
_____
_____
_____
_____

RECREATION: What are your child's favorite activities? What/who does your child play with most?
_____
_____
_____

Does your child participate in any recreational or sport activities (if yes please list them): _____
_____
_____

REGULATION/SENSORY PROCESSING:

SLEEP:
Describe your child's sleep habits. Are they able to settle down to go to sleep? How long does it take to go to sleep? Do they have difficulty sleeping through the night? Where do they sleep? If they awaken, how often? Do they awaken ready to go in the morning? In a good mood?

_____
_____
_____
_____

TRANSITIONS/CHANGE:
How does your child handle new situations, new activities, or changes in routine? Does your child have meltdowns? Frequency?

_____
_____

Does he/she tolerate new people well? Y / N
Does he/she tolerate stores? Y / N
Does he/she tolerate restaurants? Y / N
Does he/she tolerate playgrounds? Y / N

How does your child respond to:
TOUCH-Are they upset when touched by others? Picky about textures of fabrics and materials they come in contact with? (fabrics, sheets, avoid barefoot or walking on grass etc.)_____
_____
_____

MOVEMENT- Does your child seek or avoid movement, swinging, spinning, rocking? Do they tend to be cautious on playground equipment or take risks without thinking twice? Do they become upset when moved off balance?_____
_____
_____
_____

ATTENTION-Describe your child's attention. Do they have difficulty sustaining attention do they seem to over focus at times does their attention seem short or long?_____
_____
_____

SELF-CALMING- How does your child react when he/she is upset? Are they able to calm independently or do they need external assistance? What strategies do you use or they use to assist them to calm?

_____
_____
_____

BODY AWARENESS-When manipulating objects does your child tend to hold things too tightly or too loosely? Do they tend to over or under anticipate movement? Do they frequently bump into things or misjudge space?

_____
_____
_____

AUDITORY- Does your child exhibit sensitivities to any sounds? Do they tend to make excess noises? Do they seem distracted by excess environmental noise?

_____
_____
_____

GUSTATORY/OLFACTORY-Does your child exhibit sensitivities to tastes, and or smells? Do they seek after or explore things through tasting or smelling nonfood items as well as food items?

_____
_____
_____

INTERNAL SENSATION-Does your child respond appropriate to pain and temperature? Are they aware of when they are hungry, thirsty or tired?

_____
_____
_____

MOTOR CONTROL:

COORDINATION:
Describe your child's coordination. Does he/she seem to struggle with learning new movements? Are there any concerns about your child's motor skills? Are they clumsy? Performance with learning motor skills (gymnastics, soccer, etc.)_____
_____
_____
_____

GROSS MOTOR SKILLS:
Describe any concerns you have of your child's motor skills: _____
_____
_____

Are they able to: walk___run___jump___skip___hop___catch___throw a ball___bounce a ball___ ride a bike___swim___jumping jacks___

FINE MOTOR SKILLS:
Describe your child's fine motor skills and any concerns you may have:_____
_____

Hand Preference?_____Is your child able to hold a pencil and draw?_____
Describe your child's handwriting (if applicable)_____
Does your child use both hands together with ease?_____

SOCIAL SKILLS (PRAGMATICS):

Does your child have difficulty making friends? Y / N
Does your child play appropriately with toys (eg: roll ball, stack blocks, push cars): Y / N Does your child make eye contact during conversation? Y / N
Does your child prefer to be a: Follower____Leader____Play alone____

Does your child prefer to play with other children or adults?_____

Check the sentence that best describes your child's play time with other children:
Engaged in the same activity? _____
Plays beside them but not engaged with other children? _____
Does not acknowledge other children in playground? _____

Check any comments that apply to your child:
Sociable____Fearful of New Situations____Withdrawn____Aggressive____ Impulsive____Explosive____

Other Comments:_____
_____

EXPRESSIVE LANGUAGE:

How does your child communicate with you if he/she wants something?
Check all that apply:
cries___uses facial expressions___uses yes/no___point/gestures___uses one word utterance___puts two words together___uses long utterances___ answers yes/no questions____
answers wh questions (who,what,where, etc.)_____

Does your child: Talk about what they are doing_____Ask for help_____Answer questions_____

RECEPTIVE LANGUAGE:

When you talk with your child they understand:
Check all that apply:
Words____ Complete sentences____Almost everything you say___Conversations____understand one step directions___follow routine directions___follow complex directions___I need to break down everything into small steps___forgets what they are doing or distracted in the middle of the task____ **SPEECH:**

How is your child's speech?
Check all that apply:
My child substitutes one sound for another (eg: tat for cat):_____
My child drops sounds (eg: mo for mop, side for slide) _____
I cannot understand my child: _____
Others say that do not understand my child:_____

VOICE:

How does your child's voice sound to you?
Check all that apply:
Normal___Low pitched___Too soft___Immature___Hoarse or gravely___High pitched___ Too loud___Nasal (sound coming out of nose)___Denasal (sounds like a cold) ___

FLUENCY:

Does your child's speech usually flow smoothly? Y / N If
not, check all that apply:
___Repeats the first sound on many words (eg: cu-cu-can I go out to play?).
___Looks strained when trying to communicate.
___No air is released when trying to communicate.
___Repeats complete words and looks frustrated trying to communicate.

BEHAVIORAL AND EMOTIONAL COMPONENTS:

Please circle the number that best describes your child's behavior.

	Never		Occasionally Appropriate	More Often	Frequently
Compliant	1	2	3	4	5
Displays affection toward others	1	2	3	4	5
Displays aggression towards others	1	2	3	4	5
Displays aggression towards self	1	2	3	4	5
Seems irritable	1	2	3	4	5
Cries easily	1	2	3	4	5
Seems happy	1	2	3	4	5
Seems immature for age	1	2	3	4	5
Seems independent	1	2	3	4	5
Struggles to fit it	1	2	3	4	5
Understands safety awareness	1	2	3	4	5
Risk Taker	1	2	3	4	5
Needs more parental support then peers	1	2	3	4	5

CONCERNS AND GOALS:

What are your top 3 concerns about your child at this time?

_____

_____

_____

What are you hoping to receive from this referral?

_____

_____

_____

Projecting to a year later, what would you most like to see improved through therapy?

_____

_____

_____

Is there other information you feel would be helpful for me to know?

_____

_____

_____

INSURANCE AND POLICIES

INSURANCE *Required Field* (only list insurance policies your child is included on)

Subscriber's Information: *Do not list your child's information in this field, only the policy holder's*

Name (Policy holder)	
Date of Birth	
Social Security #	
Employer	

Insurance Carrier:

Primary Insurance	
ID #	
Group #	
Secondary Insurance (if applicable)	
ID #	
Group #	

APPOINTMENT REMINDERS:

I, _____ (print name), hereby authorize "TheraFUNction, Inc." to send me an appointment reminder via e-mail or text message using the following information

Email reminders may contain patient or clinic information such as, but not limited to, patient first name and clinic location.

Parent/Guardian Contact Information:

Indicate the type of reminder you wish to receive by checking the box next to either E-mail or Cell Phone (you may check both)

☐ E-mail: _____

☐ Cell Phone #: _____ Second Cell Phone # (if applicable): _____

Parent/Guardian(s) the reminders are being sent to: _____

THERAFUNCTION INC. 24 HOUR CANCELLATION POLICY

In the event that you must cancel your child's appointment, please call the office phone number 24 hours before the appointment. In the event that you are cancelling due to illness, rescheduling is still expected, and your child must be fever free for 24 hours without the use of medication before returning to the clinic. In the event that your child will be on a scheduled school field trip, please give the therapist one-week notification. Only two cancelled appointments in a quarter are permissible, and rescheduling the appointment within the next five days is expected. In the event that an appointment is cancelled and rescheduled, and the makeup session is also cancelled, two appointments will still be counted as missed in a quarter. Termination of services will be considered if two appointments have been cancelled on short notice with no makeup appointment attended in a quarter.

I, _____, understand that twenty-four hour notice must be given prior to the appointment time for my child, _____, and I am expected to reschedule the appointment within the next five days. If I fail to do so, then I will be responsible to pay a fee of $25 prior to my next visit. If fail to do so and have both Occupational and Speech Therapy appointments scheduled on the same day, I will be responsible to pay a fee of $40 prior to my next visit. I understand that my insurance will not reimburse me the cost of this fee.

Our goal is to help your child succeed at home, school and in the community. Consistency in therapy is needed for progress to be effective and rescheduling is necessary when you cancel an appointment. If twenty-four hour notice is not given two times in a quarter, termination of services will be enforced. TheraFUNction, Inc. requires that parents remain on-site during your child's therapy session. We encourage you to take part in the treatment sessions and be present to discuss strategies for carryover at home. Please help us make this partnership successful.

_____ _____

Parent Signature Date

TheraFUNction, Inc. Email and Text Message Informed Consent

TheraFUNction, Inc. provides patients the opportunity to communicate with TheraFUNction, Inc. and its employees or agents by email and text message. Transmitting confidential patient information by email and text message, however, has a number of risks, both general and specific, that patients should consider before using email and text message.

Risk Factors

- Among general email and text message risks are the following:
  - Email and text message can be immediately broadcast worldwide and be received by many intended and unintended recipients. o Recipients can forward email and text messages to other recipients without the original sender's permission or knowledge.
  - Users can easily misaddress an email or text message. Email and text messages are easier to falsify than handwritten or signed documents.
  - Backup copies of email and text message may exist even after the sender or the recipient has deleted his or her copy.

- Among specific patient email and text message risks are the following:
  - Email and text messages containing information pertaining to a patient's diagnosis and/or treatment may be included in the patient's medical or financial records. Thus, all individuals who have access to the medical record or financial record will have access to the email and text messages. Employees do not have an expectation of privacy in email that they send or receive at their place of employment. Thus, patients who send or receive email from their place of employment risk having their employer read their email.
  - If employers or others, such as insurance companies, read an employee's email or text messages and learn of medical treatment, particularly mental health, sexually transmitted diseases, or alcohol and drug abuse information, they may discriminate against the employee/patient. For example, they may fire the employee, not promote the employee, deny insurance coverage, and the like. In addition, the employee could suffer social stigma from the disclosure of such information.
  - Patients have no way of anticipating how soon TheraFUNction, Inc. and its employees and agents will respond to a particular email or text message. Although TheraFUNction, Inc. and its employees and agents will endeavor to read and respond to email or text messages promptly, TheraFUNction, Inc. cannot guarantee that any particular email or text message will be read and responded to within any particular period of time. TheraFUNction, Inc.'s employees and agents may be traveling, be engaged in other duties, or be on a vacation or a break and therefore be unable to continually monitor whether they have received email or text message. Thus, patients should not use email or text messages in a medical or other emergency.

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Conditions for the Use of Email and Text Message

- It is the policy of TheraFUNction, Inc. to make all email and text messages sent or received that concern the protected health information ("PHI"), defined as individually identifiable health information that includes medical, financial, demographic, and lifestyle information, part of that patient's medical, financial, or other records, and TheraFUNction, Inc. will treat such email and text messages with the same degree of confidentiality as afforded other portions of the medical record. TheraFUNction, Inc. will use reasonable means to protect the security and confidentiality of email and text information. Because of the risks outlined above, TheraFUNction, Inc. cannot, however, guarantee the security and confidentiality of email and text communications.

- Thus, patients must consent to the use of email and text for confidential medical information after having been informed of the above risks. Consent to the use of email and text includes agreement with the following conditions:
    - All email and texts to or from the patient concerning diagnosis and/or treatment will be made a part of the patient's records. As a part of medical record or other records, other individuals, such as other physicians, nurses, physical therapists, patient accounts personnel, and the like, and other entities, such as other health care providers and insurers, may have access to email and text messages contained in medical records.
    - TheraFUNction, Inc. may forward email and text messages within the facility as necessary for diagnosis, treatment, and reimbursement. TheraFUNction, Inc. will not, however, forward the email and text outside the facility without the consent of the patient or as required by law.
    - If the patient sends an email and/or text message to TheraFUNction, Inc., one of its employees or agents will endeavor to read the email and/or text message promptly and to respond promptly, if warranted. TheraFUNction, Inc., however, can provide no assurance that the recipient of a particular email and/or text message will read the email message promptly. **Because TheraFUNction, Inc. cannot assure patients that recipients will read email and/or text messages promptly, patients must not use email and/or text messages in a medical or other emergency.**
    - If a patient's email and/or text message requires or invites a response, and the recipient does not respond within a reasonable time, the patient is responsible for following up to determine whether the intended recipient has received the email and/or text message and when the recipient will respond.
    - Because some medical information is so sensitive that unauthorized disclosure can be very damaging, **patients should not use email and/or text for communications concerning diagnosis or treatment of the following: AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; mental health or developmental disability; or alcohol and drug abuse.** Because employees do not have a right of privacy in their employer's email system, patients should not use their employer's email system to transmit or receive confidential medical information. TheraFUNction, Inc. cannot guarantee that electronic communications will be private. TheraFUNction, Inc. will take reasonable steps to protect the confidentiality of patient email and/or text message, but TheraFUNction, Inc. is not liable for improper disclosure of confidential information not caused by TheraFUNction, Inc.'s gross negligence or wanton misconduct.
    - If the patient consents to the use of email and/or text message, the patient is responsible for informing TheraFUNction, Inc. of any types of information that the patient does not want to be sent by email and/or text message other than those set out above.
    - Patient is responsible for protecting patient's password or other means of access to email and/or text messages sent or received from TheraFUNction, Inc. to protect confidentiality.

      TheraFUNction, Inc. is not liable for breaches of confidentiality caused by patient.
    - **Any further use of email and/or text message by the patient that discusses diagnosis or treatment by the patient constitutes informed consent to the foregoing.** You may withdraw consent to the future use of email and/or text message at any time by email or written communication to TheraFUNction, Inc., attention: Jodi Jennings, Clinical Director.

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THERAFUNCTION'S HIPAA POLICIES

NOTICE OF PATIENT INFORMATION PRACTICE

This notice describes how medical information about you may be used or disclosed by this Practice and how you can get access to information. Please review it carefully. Notice of Privacy Practices in detail are located underneath the sign in sheet.

LEGAL DUTY: This practice is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described here.

USES AND DISCLOSURES OF HEALTH INFORMATION: This practice uses your health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. We may also use or disclose your personal health information for public health purposes, audits, emergencies and when required by law.

In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

PATIENTS INDIVIDUAL RIGHTS: You have the right to review or obtain a copy of your personal health information at any times. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. We will consider all such requests on a case by case basis, but the company is not legally required to accept them.

CONCERNS AND COMPLAINTS: If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact the Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services.

TheraFUNction, Inc., 1300 McGee Drive, Suite 113, Norman, OK 73072 (405)366-7898

PATIENT INFORMATION CONSENT FORM FOR HIPAA COMPLIANCE

I have read and understand the attached Notice of Patient Information Practices. I understand that the company 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 and payment and administrative operation if I notify the company. I also understand that this practice will consider requests for restrictions on a case by case basis and 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 on the Company's Notice of Patient Information Practices. In doing so, I hereby release TheraFUNction, Inc. from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time except for that action which has already been taken. It shall be effective only long enough to answer the purpose of which it is given and no further confidential information will be released without the execution of an additional written authorization.

LIST OF ITEMS NEEDED FOR DAY OF EVALUATION:

- IEP (if applicable)
- Insurance cards
- Childcare; the therapists will often speak to parents privately during the evaluation. Please bring someone who is able to watch your child and/or siblings during this time.

Please read carefully:

I authorize permission for Jodi Jennings, OTR/L, Joan Berryhill, OTR/L, Jessica Wilkinson, MOT, Patty Smith, COTA/L, Erin Lawson, MOTR/L, Melanie Ridgway, OTR/L, and Rachel Griffin, OTD, to provide Occupational Therapy and/or Jenine “Nina” Riemer, MA, CCC-SLP to provide Speech Therapy for my child and/or Cassiopeia “Cassi" Krieger, MPT, to provide Physical Therapy. I authorize TheraFUNction’s use of information on this form for submitting insurance claims for services rendered. I authorize release of information or other documentation regarding services rendered to all my insurance providers and physicians.

I understand that I am responsible for the amount charged for services rendered that my insurance doesn’t cover. I understand that it is my responsibility to notify TheraFUNction if my referring physician or insurance changes. I authorize TheraFUNction to act as my agent in helping obtain payment from my insurance companies. I authorize payment for services rendered directly to TheraFUNction, Inc.

By signing these forms, you agree to all terms and conditions in the New Client Questionnaire.

_____

Parent/Guardian’s Name (Printed)

_____ _____

Parent/Guardian’s Signature Date

_____ _____

TheraFUNction Representative Date

Parental Consent Form

* **Form must be completed in its entirety or will not be accepted**

Member Name: _____
Member RID #: _____
Member Diagnosis: _____

I (print name of parent/legal guardian)_____
hereby authorize (print name of provider) _____
to evaluate, as well as provide any subsequent treatment based on the evaluation results for (please check all services that apply) _____ Physical Therapy, _____ Occupational Therapy and/or _____Speech Therapy for child named above.

_____
Signature of Parent/Legal Guardian if a minor

_____
Date Signed by Parent/Legal Guardian

_____
Relationship to Member

_____
Signature of Therapist or Representative of Therapy Group

_____
Date Signed by Provider