

BODYBENDERS

THErapy WITH A TWIST

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: (Father) _____ (Mother) _____

Parent's Marital Status (Married, Single, Divorced, Widowed): _____

Home Address: _____

E-mail Address: _____

- Please check if you consent to correspondence through email.

Phone: (Home) _____ (Cell) _____

Father's Occupation: _____ Employer: _____

Work Address: _____ Phone: _____

Mother's Occupation: _____ Employer: _____

Work Address: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Is there anyone involved in the routine payment or care of this patient with whom we may share medical information (caregivers, friends, extended family)? _____

Please check if you DO NOT consent to any of the following:

- I do not provide consent for messages to be left on my voice mail/answering machine.
- I do not provide consent for messages to be left with any other person in the household besides the parents/guardians.

Referring Physician: _____ Phone: _____

Date of last visit: _____ Date of next visit: _____

Primary Care Physician: _____ Phone: _____

Specialists: _____ Phone: _____

_____ Phone: _____

School/Grade: _____ Phone: _____

School Therapists: _____ Time per week: _____

OVER

Diagnosis/Condition: _____ Date of Onset: _____

Gestational history: _____

Birth history: _____

Prior Hospitalizations/Surgeries: _____

Medications: _____

Allergies: _____

Equipment: _____

Vendor: _____ Phone: _____

Developmental Milestones (please indicate the approximate age when the child achieved the following):

Rolling _____ Sitting _____ Crawling _____

Standing _____ Walking _____

Physical Therapy Goals/Expectations:

Is there anything you feel we should know that we have not asked? If yes, please explain:

I, the undersigned, do hereby certify that I have understood and completed the above information and know it to be truthful and accurate to the best of my knowledge. I grant permission for designated personnel of BodyBenders to provide services for my child. This agreement will remain in effect until revoked by me in writing. A photocopy or facsimile of this document is to be considered as valid as an original. *I understand that I am responsible for full payment of all services rendered. I have been offered the Notice of Patients' Rights and I consent to physical therapy for my child. I have read and agree to BodyBenders' Policies and Procedures.*

Parent/Guardian Signature _____ Date _____