Cynthia Miles & Associates LLC.

Date

Child's Full Name Birth Date

Home Address City State Zip Code

Child's Social Security # ( ) Home Phone #

Mother's Full Name Birth Date

Home Address City State Zip Code

Mother's Social Security # ( ) Home Phone #

( ) Work Phone # ( ) Cell Phone # Email

Employer's Name & Address

Father's Full Name Birth Date

Home Address City State Zip Code

Father's Social Security # ( ) Home Phone #

( ) Work Phone # ( ) Cell Phone # Email

Employer's Name & Address

Emergency Contact Name ( ) Home Phone # ( ) Cell Phone #

Referring Physician Physician's Phone

Reason for Referral Diagnosis

Family Physician Family Physician Phone #

Orthopedist Neurologist

Has child ever been treated for torticollis? Yes/No

Allergies

Surgical / Illness History

Other Programs and Related Services

Siblings Name / Age

Current Patient Information:

Gender: **M/ F** Race:__________________________ Weight:______ Length:________________

Height/Weight Percentile:_________ Head Circumference:_____________ Apgars:_________ Birth Order:______

Was child born prematurely? **Yes / No** If yes: Chronological Age:___________ Gestational Age:_______________

Was child breastfed? **Yes / No** Mom's age at time of birth: ____

Where was your child born?

Name of Hospital:____

Who was your Ob/Gyn:____

Name of Birth Center:____

Home: ____

Weight at Birth:_______________ Length at Birth: ______________ Length of Hospital Stay:_________________

Type of Delivery: __________________ Utero Position:______________ Attendance at a Pre-Natal Class: **Yes** / **No**

Births: **Single / Multiple** If multiple how many? ____

List any complications during pregnancy (bed rest/low back pain/ leg pain):___________________________________

____

List any complications during delivery:____

____

List any medications taken by mother during pregnancy:____

____

List any medications taken by mother during delivery:____

____

Was your child admitted to NICU or did he/she remain in newborn nursery?___________________________________

Did your child receive physical therapy services prior to returning home (in NICU, PICU, or nursery)?_____________

____

Child's Sleep Position: __Supine (on back) __Side __Prone (on tummy) __Other:___________________
Explain

If applicable, does your child snore? **Yes / No** Does your child have frequent ear infections? **Yes / No**

Please list the age of child at the following milestones (in months):

Started walking:_____ Started talking:______ Eating Table Food:_________

Mouthing of toys/hands:_____ Cereal introduced:____ Pacifier use:________

What kind of food/formula does your child eat?____

____

How does your child typically communicate? gestures / single words / short phrases / sentences **Circle one**

Is your child understood by others or just family members?____

Where do you generally seek information on your child's development?______________________________________

____

Emergency Treatment Permission

I give my permission for a staff member of Cynthia Miles & Associates to take me and/or my child to a Hospital Emergency Room for me and/or my child's Treatment if the need for Emergency Care arises. I hereby give my permission for the staff member to respond by activating EMS (Dialing 911), Initiating Rescue Breathing and/or Basic CPR Procedures and/or Basic First Aid if appropriate. I therefore accept full responsibility for whatever consequences may occur and hold Cynthia Miles & Associates, LLC. to **NO** Legal or Medical Liabilities.

Signed:____________________________________ Date:___________________________

Child's Name:____

**********************************OR**************************************

I have read the above stated emergency permission statement and **DO NOT** grant staff members of Cynthia Miles & Associates permission to initiate Basic Emergency Procedures in the event that a staff member would be present during a medical emergency in which I, myself, was unable to perform necessary Emergency Procedures. I therefore accept FULL Responsibility for whatever consequences may occur and Hold Cynthia Miles & Associates, LLC to **NO** Legal or Medical Liabilities.

Signed:____________________________________ Date:______________________

Child's Name: ____

*Special Instruction or Restrictions:____

____

____

Consent to Obtain or Release Information

I authorize Cynthia Miles & Associates to obtain or release information regarding my son/daughter

________________________________ Date of Birth:_______________________________

This information exchange is of the purpose of providing Physical, Occupational, Speech Therapy and/or Special Instruction Programs which will meet the needs of my child. This includes providing treatment, procuring payment and conducting health care operations. I understand that in order to protect confidentiality of records, my agreement to obtain or release information is necessary. The information will only be shared as necessary to provide quality treatment and communication between your primary Health Care, Educational, and Payment Providers. I understand that by written statement, to Cynthia Miles & Associates, I may withdraw my permission at any time.

This consent will be in effect throughout the duration of my child's treatment regime. It is effective for all Physical, Occupational, Speech Therapists and teachers at Cynthia Miles & Associates who treat and/or have contact with my child.

Please be advised we make every effort to maintain strict confidentiality for all of our clients. However, due to our open concept design, information about your child may be overheard.

Permission to Photograph your child: Yes_______ No________
Permission to display photograph of your child: Yes_______ No________
Permission to video tape your child: Yes_______ No________

Parent/Guardian_______________________________________ Date:___________

OPTIONAL: This release of information or ability to obtain information is Limited to the following:

____

____

HOME POLICY AND INFORMATION

CLIENT CANCELLATION POLICY:

We realize that in the world of children and busy families, cancellations are sometimes inevitable. With this in mind, we ask that when cancellation of your child's physical, occupational, speech therapy or special instruction appointment is absolutely necessary you give us a call as far in advance as possible. 24-hour notice is preferred but considerations for sudden illness will be made. We are happy to re-schedule missed appointments if possible, but please understand that most of our schedules are quite full and availability of make-up times may be very limited.

Unfortunately, due to our leniency and abuse of "NO-SHOWS" in the past, we find it necessary to hold the following "NO-SHOWS" Policy. The first appointment which is missed without notification of cancellation to our office by the time of the appointment will result in a phone call to remind you of the missed appointment and to re-schedule, if possible. The third missed appointment without notification to our office will result in termination of services for your child. Of course, special emergency circumstances will be considered.

We believe that your commitment to your child's therapy schedule is essential to his or her progress and ultimate development. We thank you in advance for your cooperation in this matter. Helping your child to reach his or her maximum potential is both our privilege and pleasure.

THERAPY SESSIONS:

HOME VISITS: Please keep in mind therapy sessions are usually scheduled for one hour time periods. Please take into consideration that the therapist could be a few minutes early or late due to traffic conditions, which are beyond their control. If you have any questions to discuss with your therapist, please do so during their session as in most cases they must leave to travel to another visit. Also, keep in mind therapists take their toy bags from home to home. Many of their clients are medically fragile and therefore are allergic to smoke and/or pet dander. Please refrain from smoking in their presence and keep pets away.

SIBLING POLICY:

HOME VISITS: We ask that parents supervise all siblings so they do not disrupt your child's therapy session. Your cooperation in this matter is greatly appreciated.