"We look forward to the opportunity to serve you and your child."

Southern PEDIATRIC THERAPY Clinic

1620 HWY 11 N STE C
Picayune, MS 39466
P: 769-242-2139
F: 601-255-8629

Patient's Name: _____ Date of Birth: _____ Age: Sex: M / F

Address: _____

City: _____ State: _____ **Zip**: _____ SSN: _____

Is this child in school? Yes / No Is the patient a foster child? Yes / No

Additional information regarding care, custody, contact, and restrictions: _____

_____

Guardian's Name (1): _____ Relationship to Child: _____

Address: _____ City: _____ State: _____

Zip: _____ Preferred Phone: _____ Home / Work / Cell

Alt Phone: _____ Home / Work / Cell E-mail: _____

Guardian's Name (2): _____ Relationship to Child: _____

Address: _____ City: _____ State: _____

Zip: _____ Preferred Phone: _____ Home / Work / Cell

Alt Phone: _____ Home / Work / Cell E-mail: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Physician/Pediatrician (Name and Facility): _____

Primary Insurance: Insurance Company: _____

Policy Holder's Name : _____ DOB: _____ SSN: _____

Secondary Insurance: Insurance Company: _____

Policy Holder's Name : _____ DOB: _____ SSN: _____

Family Information

Please write down all household members living with the child

Name:	**Relationship to child:**	**Age/Occupation:**
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Name:	**Relationship to child:**	**Age/Occupation:**

Significant medical conditions, surgeries, or injuries: _____

_____

Medications: _____

Allergies: _____

Please list any significant prenatal or birth history: _____

_____

Length of pregnancy (weeks): _____ C-section: No / Yes: Emergency / Planned? No / Yes

Any complications after delivery? _____ NICU stay: No / Yes: _____ weeks

Has your child's hearing or vision been checked recently? Yes / No Results: _____

What are your primary areas of concern? _____

_____

What are your child's strengths? _____

_____

What are your family's goals for therapy? _____

_____

Please list any behavioral or social concerns: _____

Has your child ever received physical therapy before? Yes/No

Has your child ever received occupational therapy before? Yes/No

Has your child ever received speech therapy before? Yes/No

Does your child use any adaptive equipment? No / Yes: _____

Does your child receive school therapy services or early intervention through an IEP or IFSP? Yes / No

Is there anything else that you feel would be beneficial for us to know about your child? _____

_____

_____

How did you hear about us? Who can we thank for your referral? _____

Thank you for taking the time to fill out this questionnaire. This information will help us to become more familiar with your child so that we can provide the best service possible to you and your child.

Patient's Name: _____

Parent/Guardian Name: _____ Relationship: _____

Parent/Guardian Signature: _____ Date: _____