Keystone
Pediatric Developmental Center
a service of Keystone Health

Dear Family,

Welcome to Keystone Pediatric Developmental Center. Thank you for scheduling an evaluation with us. The following information is important to read prior to your appointment.

1. Please make sure you complete the intake packet prior to your scheduled appointment.
2. Your child's evaluation should take about 1 to 2-½ hours, depending on your child's age and the amount of standardized testing needed. In most cases, parents are asked to "sit in" with us, so that you can observe and so your child will feel more comfortable.
3. We evaluate babies in their diapers. For toddlers or older children, we ask that you bring gym shorts, a bathing suit, or a leotard.
4. You may bring a small snack if you think your child might need one, during or at the conclusion of their evaluation.
5. All of our therapists are experts in handling children; so much of the process involves toys and fun equipment. Most children thoroughly enjoy themselves.

Completed packets can also be:

Mailed to:
Keystone Pediatric Developmental Center
111 Chambers Hill Drive, Suite 101
Chambersburg, PA, 17201
(At least 1 week prior to scheduled appointment)

Faxed to: (717) 261-4725

We look forward to meeting with you and your child. Please give us a call at (717) 709-7997 if you have any questions

PATIENT REGISTRATION

Patient Information

Name: _____
First *Middle* *Last*

Address: _____

Social Security Number: _____Home phone: (____)_____ Cell Phone: (____)_____

Date of Birth: _____ Marital Status: _____ Gender: ◯ M ◯ F

Race: ◯ American Indian/Alaska Native ◯ Asian ◯ Black ◯ White ◯ Native Hawaiian ◯ Other Pacific Islander

Ethnicity: ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Do you have medical insurance? ◯ Yes ◯ No

If you do not have insurance, would you like to get information about our reduced fee program? ◯ Yes ◯ No

Are you a US veteran? ◯ Yes ◯ No Are you homeless? ◯ Yes ◯ No

Parent's Information (Complete this section for a patient less than 18 years old)

Mother's Name: _____ Date of Birth:_____/_____/_____
First *Middle* *Last*

Father's Name: _____ Date of Birth:_____/_____/_____
First *Middle* *Last*

Is there a Legal Child Custody Agreement? ◯ Yes ◯ No

(If yes, are there any legal restrictions that would prevent the non-custodial parent from consenting to medical/dental treatment for the child or from obtaining information about the child's medical/dental treatment?) ◯ Yes ◯ No

*****Please provide proof of parental custody orders or other legal agreements*****

Emergency Contact Person

Name:_____/_____
First *Middle* *Last* *Relationship to patient*

_____/_____
Address *Phone*

Person Responsible for Payment (Complete this section for a patient less than 18 years old)

Name:_____/_____
First *Middle* *Last* *Relationship to patient*

Social Security Number: _____ Date of Birth: _____

Address: _____

Home phone: _____ Cell phone: _____

I agree that the above information is correct and accurate to the best of my knowledge. I also understand that any charge(s) not covered by my insurance(s) will be my responsibility.

Signature: _____ Date: _____

For Office Use Chart #: Insurance scanned: yes/no Date: Initials:

1/2/19 ksw

PERMISSION TO SHARE PROTECTED
HEALTH INFORMATION

Patient's Full Name: _____
(First) (Middle) (Last)

Patient's Date of Birth: _____/_____/_____Telephone:_____

Keystone Health shares one electronic record. Any person(s) you authorize will have access to your financial/medical/dental and behavioral health information.

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Keystone Health uses a reminder system and/or patient portal to communicate with our patients. Please complete the information below, so that we may keep in touch with you regarding your health.

Cell Phone:_____(you will receive a text message)

E-mail:_____ (you will receive an email)

By signing, I give permission to Keystone Health to share my protected health information to the individuals listed. This permission remains in effect until revoked in writing.

_____ _____

Signature of Patient or Authorized Representative Date

(Patients 14 years and older must sign if consenting for treatment on own behalf)

_____

Staff Initials

PERMISSION FOR TREATMENT OF
CHILDREN

Patient's Full Name: _____
(First) (Middle) (Last)

Patient's Date of Birth: _____/_____/_____

Name of Parent/Legal Guardian: _____

If I can't bring my child to a medical/behavioral health or dental appointment, I give permission for the person(s) listed below to go with my child to visits at Keystone Health Center. He/she can also approve treatment for my child during the visit, including shots and minor dental and medical procedures.

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Please Note: Sometimes, the provider may decide that a parent must be present for certain dental procedures: extractions, root canals, surgical procedures, nitrous visits and operating room visits.

This permission remains in effect until revoked in writing.

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

_____
Staff Initials

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PATIENT HISTORY FORM

Patient Name:_____**Age/DOB:**_____

Parents'/Guardians' Names:_____

PCP Name: _____

Address:_____

Phone: _____ **Fax** _____

Family Information:

Language(s) spoken in the home:_____

Names and ages of siblings:_____

Names and types of pets:_____

Home situation (parents married/divorced?): _____

Child lives with: _____

List Current Concerns/Problem Areas:_____

_____

_____

Patient/Care-Giver Goals (In your own words, what would you like to achieve in therapy):

_____

_____

Medical History

List any significant Medical History *(chronic ear infections/ tubes/ reflux/ surgeries, illness, hospitalization, etc...):*

___Chronic ear infections	___Seizures
___Tubes	___Vision deficits
___Tonsils/Adenoid Surgery	___Hearing problems
___Reflux	___Torticollis
___Surgeries: list above	___Frequent antibiotic use
___Poor sleep	___Frequent fevers
___Colic	___Compromised immune system
___Asthma	___Abnormal Lab results
___Allergies	___Cardiac Issues
___Abnormal muscle tone	___Lyme Disease
___Hearing defect	___Poor weight gain
___Physical injuries	___Other:
___Meningitis	___Other:

Additional Diagnosis: Please indicate any medical diagnosis or medical condition below:

_____

_____

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Patient Name_____ DOB _____

Hospitalizations, Surgeries, & Diagnostic Testing (please list)

_____

_____

_____

Allergies/Reactions (food, latex, medication, other - please list):

_____

_____

Medication: Please include prescription drugs, over the counter medication, vitamins, and homeopathic medications.

Medication: _____ Purpose: _____

Medication: _____ Purpose: _____

Medication: _____ Purpose: _____

Medication: _____ Purpose: _____

Medication: _____ Purpose: _____

Medication: _____ Purpose: _____

Precautions/Contraindications: _____

_____

_____

Equipment/Orthotics: _____

Birth History:

___Full Term ___Premature _____ wks Birth Weight: _____

___Vaginal Delivery ___Caesarean Delivery

How long was your child in the hospital following his/her birth? _____

Please describe any complications with the pregnancy or delivery: _____

_____

_____

Developmental History: Please list in months when the following first occurred:

Held up head: _____ Craw:l _____
Rolling tummy to back: _____ Rolling back to tummy: _____
Sitting without support: _____ Walking: _____
Smile: _____ First words: _____
Finger foods: _____ Use a spoon: _____
Dress self: _____ Potty trained:_____

Hand Dominance: ___Right ___Left ___Not Sure

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Patient Name _____ DOB _____

Other Therapeutic Services:

Occupational Therapist: _____ School/Clinic:_____
Physical Therapist: _____ School/Clinic:_____
Speech Therapist: _____ School/Clinic:_____

Other Services:
Please list any other professionals and agencies who are currently seeing or have seen your child:

	Name	Phone #
Case Worker:		
Early Intervention:		
Neurologist:		
Gastroenterologist:		
Ear Nose and Throat (ENT):		
Other Specialist -Physician:		
Mental Health/Behaviorist:		
Audiologist:		
Nutritionist/Dietician:		
Public Health Nurse:		
Other:*		

Please list any other information you would like your therapist(s) to know: _____

_____

Academic/ Educational History

___School/Pre-School: _____ Grade: _____
___Is not enrolled in school/pre-school

My child... (*Fill in the blanks and check appropriate boxes that describe your child)*

___Does well in school: _____
___Does well with the exception of: _____
___Is challenged by school: _____
___Is challenged by writing: _____
___Is challenged by reading: _____
___Receives resource/ tutoring for: _____
___Receives classroom support for: _____
___Is an A B C D F Student
___Is in a self-contained classroom

List any academic/school concerns: _____

_____

List specific teacher concerns: _____

_____

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Patient Name_____ DOB _____

About Your Child:

Every child is uniquely different. In order to understand your child and his/her present abilities, it is helpful to learn about your child in order to provide the most comprehensive assessment and treatment plan to meet his/her needs. Please complete the following and use additional paper if needed:

1. What kinds of things does your child enjoy? _____
_____

2. What do you especially enjoy about your child? _____
_____

3. What major concerns do you have for your child? Why are you seeking occupational therapy?
_____
_____

4. Describe your child's gross motor skills (can your child walk, run, throw, catch a ball, ride a trike/bike with or without training wheels)? _____
_____
_____

5. Describe your child's fine motor skills (How does your child manage a fork/spook/knife? Can your child use a pencil, crayon and scissors? How does your child pick things up or manipulate objects?
_____
_____

6. Does your child need assistance with dressing? If so, how? _____
_____

7. Does your child need help with snaps, buttons, or zippers? _____
_____

8. Is your child able to tie his/her shoes? _____

9. Does your child need help taking a bath? Can your child adjust the water temperature, and wash his/her hair and body thoroughly?_____
_____

10. Does your child need help brushing teeth? _____

11. Does your child need help brushing his hair? _____

12. Is your child able to do simple chores around the house? _____
_____

13. Does your child enjoy playing with other children or playing alone? _____
_____

14. How does your child communicate with you and familiar people? _____
_____

15. Does your child do better with routine? What happens if the routine is altered?
_____
_____

16. How does your child sleep? Does he/she sleep through the night? Do you have a bedtime routine? Does your child have difficulty getting to sleep? Does your child have difficulty getting up in the morning?
_____
_____
_____

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17. **How well does your child do in the community (stores, mall, restaurants, offices, etc.)? Does your child tolerate the activity around him/her?**_____
_____
_____

18. **Describe your child's attention span. Can he/she work for long periods? Does he/she need supervision and assistance to get tasks done? How does he/she do with preferred tasks versus non-preferred tasks? What is the maximum he/she can sit and do an activity and what is his/her average attention span?**

_____
_____
_____
_____

19. **How does your child do with transitions? For example, leaving the park, getting into the car go to the store, putting toys away for dinner?** _____
_____
_____

20. **What are your child's strengths?** _____
_____
_____

21. **What area(s) does your child need to improve?** _____
_____
_____

22. **From when your child gets up to when he/she goes to bed, describe a typical day. Use additional paper if necessary. Please be as specific as possible.**

_____
_____
_____
_____
_____
_____
_____
_____

Behavior/Social History:

My child... (*Check appropriate boxes that describe your child*)

___Is social and engaging
___Makes good eye contact with adults and peers
___Is well behaved
___Pays attention
___Listens well
___Follows directions well
___Takes turns with peers
___Is easy going
___Plays well with other children
___Does well with change
___Understands safety
___Is aggressive
___Is oppositional
___Has tantrums

List any behavior / social concerns:

_____
_____

Any other comments about your child:

_____
_____

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Patient Name _____ DOB _____

Sensory History:

My child... (*Check appropriate boxes that describe your child*)
___Is sensitive to sound
___Is sensitive to light
___Is distracted by busy environments
___Avoids crowds
___Gets upset or withdraws from loud noises
___Fixates on spinning objects
___Fixates on shiny objects
___Avoids touching objects or textures
___Is sensitive to clothing tags
___Is sensitive to seams in clothing or socks
___Avoids a certain texture food (crunchy, mushy, mixed, chewy)
___Quickly escalates without apparent cause
___Extremely sensitive to criticism
___Unable to self-calm
___Poor coping skills
___Is very busy and active
___Has difficulty paying attention
___Has difficulty listening
___Has difficulty following directions
___Prefers to play alone
___Has difficulty with transitions
___Is ritualistic with play
___Does not like crowds
___Does not like new places/people
___Avoids a certain taste (salty, sweet, sour, spicy, bland)
___Is a picky eater
___Avoids certain smells
___Avoids heights
___Avoids movement activities
___Avoids playground equipment
___Avoids slides
___Avoids swings
___Is clumsy
___Gets dizzy easily
___Has poor balance
___Has poor sense of body and self
___Enjoys the playground
___Enjoys rough and tumble play
___Is a good eater
___Enjoys a variety of textured foods
___Overstuffs when eating and/or pockets food
___Seeks out excessive movement throughout the day
___Can't sit still
___Difficulty regulating states of arousal/activity level
___Doesn't seem to register pain
___Doesn't seem to notice temperature extremes
___Enjoys a variety of textures play activities
___Likes to play in the bath
___Enjoys swimming or water play
___Likes messy play
___Likes to play with his/her food
___Eats sticky/messy food with fingers (French toast sticks with syrup, French fries with ketchup, peanut butter and Jelly, etc.…

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Patient Name _____ DOB _____

Food Permission/Dietary Information

Please list any allergies your child may have, including food, non-food, and/or latex:

_____
_____

Please complete the following to allow your child to participate in snack activities:

_____ My child may participate in snacks and has no diet restrictions.

_____ My child may participate in snacks if diet restrictions are observed.
Diet Restrictions: _____
_____

_____ My child may participate in snacks; however, I will provide his/her snack.

_____ My child should **not** participate in snack time. Please list the food(s) your child is motivated to eat: _____
_____

_____ _____ _____
Parent/Guardian Signature Relationship Date

Therapist/Witness _____Date: _____