Locations:
Fort Worth
Dallas
Colleyville

PTFW
817-247-1130
Fax: 817-292-7930
Tax ID #: 38-3707153

Dear Valued Patient:

Welcome to PTFW. It is my goal to provide you with physical therapy that will help your child reach his/her maximum potential. Cooperative effort is the key to success in therapy treatment. Cooperation not only with you, but also with your physician, other health care providers, and your family is important in obtaining your goals.

At PTFW, **I look at the person as a whole**, not just the body region that is impaired. I am privileged to work with other health care providers as an interdisciplinary team, taking into account the whole person. Each treatment session includes direct treatment, consultation, home programming, and documentation of the services. Direct treatment addresses the goals and objectives established in your treatment plan. Consultation includes updating current issues and concerns. Home programming involves patients and family members in the overall success of treatment. Documentation at the time of service assures accurate documentation of the events of the session. You may expect the direct therapy portion of the session to end approximately 5 minutes before the scheduled end of the session to allow time to document the events and to clarify your questions.

One of my goals is to begin and end sessions in a timely manner. I recognize that your time is valuable. Therefore, if there is ever a time when you have not been escorted into treatment within 10 minutes following your scheduled appointment, please inform the receptionist. In order for your treatment plan to be effective, you must adhere to the appointments as they have been recommended and scheduled. Should an occasion arise that you will be unable to keep your scheduled appointment, I ask that you call in advance to reschedule your appointment. You may lose your regularly scheduled treatment time or be discharged from therapy if you miss 3 appointments without notifying me in advance and/or you may be charged for those missed sessions. This is a courtesy to all of the patients, so that I can optimize my appointments to everyone's benefit.

I welcome you to PTFW, and trust that you will achieve your maximum potential of rehabilitation. I look forward to serving you, while reaching and improving upon my standards of excellence.

Sincerely yours,

Pamela Jones, M.S., PT, MT
PTFW

Please note that we are a perfume/cologne-free environment, due to sensitivities of customers and staff.

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PATIENT INFORMATION

Patient's Name ______________________________ DOB _________ Age ____________

Gender ☐ Male ☐ Female

Street ___________________________________ Home Phone # __________________

City _____________________________ State _____________ Zip Code _____________

GUARANTOR INFORMATION

Father's Name_______________________ DOB ________

Street Address_________________________ Home Phone____________ Cell # __________

City ____________________________ State _________ Zip Code ___________________

Employer ______________________ Occupation _____________ Phone ______________

Mother's Name_______________________ DOB ________

Street Address_________________________ Home Phone____________ Cell # __________

City ____________________________ State _________ Zip Code ___________________

Employer ______________________ Occupation _____________ Phone ______________

Who may we thank for your referral?_________________ Physician(s) ________________

Diagnoses ____

Do you Text (for confirmation of appointments)? ☐ Yes ☐ No { ☐ Mom ☐ Dad}

I understand that I am responsible for my child's bill.

Parent/Guardian's signature __________________________ Date _________________

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CONDITIONS AND CONSENT FOR OUTPATIENT EVALUATION AND TREATMENT

I. COOPERATION WITH EVALUATION AND TREATMENT:

A. I understand that in order for therapy to be effective, I must come as recommended and scheduled unless there are unusual circumstances that prevent me from attending therapy.

B. I understand that I may be discharged from therapy if I fail to keep three (3) appointments without calling to cancel.

C. I agree to cooperate with the home program assigned to me. If I have difficulty, I will discuss this with my therapist.

II. NO WARRANTY:

PTFW does not promise a cure for my condition. They will discuss treatment options with me.

III. INFORMED CONSENT TO EVALUATE AND TREAT

The term "informed consent" means that the potential risks, benefits and alternatives of the therapy evaluation and treatment have been explained to you. The facility provides a wide scope of services and you will receive information at the initial treatment session on the treatment options available for your condition.

A. **Potential Risks:**
If your evaluation or treatment is for musculoskeletal or neurological dysfunction, you may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury. This discomfort is typically temporary and will probably subside in 24 hours.

B. **Potential Benefits:**
These include an improvement in your symptoms and/or an increase in your ability to perform your daily activities. You will have greater knowledge on managing your condition and the resources available to you. If your treatment sessions are for musculoskeletal or neurological dysfunction, you may experience increased strength, awareness, flexibility and endurance in your movements. You may experience decreased pain.

C. **Alternatives:**
If you do not wish to participate in the recommended evaluation or treatment program, you may discuss this with your therapist. Your therapist may then refer you back to your physician to discuss your medical, surgical, or pharmacological alternatives.

Based on the information I have received from the therapist, I voluntarily consent for my child to have a physical therapy evaluation and/or treatment. I understand that I may withdraw my child at any time.

PARENT/GUARDIAN'S SIGNATURE	PARENT/GUARDIAN'S PRINTED NAME	DOB	DATE

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FINANCIAL INFORMATION FOR PATIENTS

CHARGES AND PAYMENTS: PTFW's fee schedule and payment options can be discussed prior to the rendering of services. Payments are due when services are rendered. PTFW will charge a return check fee of **$30.00** per returned check. Returned check fee must be paid in cash.

CANCELLATION: Your appointment time is scheduled specifically for you, therefore PTFW requires prior notification of cancellation of all therapy sessions. Failure to cancel an appointment may result in billing for the full regular fee.

INSURANCE: THE PATIENT IS RESPONSIBLE FOR ALL CHARGES. As a courtesy, PTFW will provide you with the necessary information for you to file with your primary insurance company. If additional information is requested by your insurance company beyond the normal information, additional fees may be applied to your account.

Payment in full is required at the time services are rendered. You may pay by check or cash. In order to keep cost down, credit cards are not accepted.

______________________________ ______________________________
Patient/Guarantor Signature **Printed Name of Patient/Guarantor**

______________________________ ______________________________
Name of Patient **Date of Birth of Patient**

____
Date

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Consent to Release Information

Patient's Name:____
(Last) (First) (Middle)

Date of Birth:____________________

I, ________________________________, Parent/Guardian for the above listed child, give permission for **PTFW**, **an agency, or the physician** listed below to **release and/or share** medical information (Written/Oral). I understand that my consent is voluntary and may be revoked at any time by written statement submitted to PTFW.

Physician/Agency/Person:____

Address: ____

____

Telephone: ________________________ Fax: ___________________________

____ ________________________
Parent/Guardian's Signature Date

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Child's Name ________________________________ ☐ M ☐ F Date ______________
DOB ________________________________ Age ________________________________
Current Height ________________________________ Current Weight ______________________
Diagnosis ________________________________ Doctor ________________________________

Person completing form ____
Relationship to child ____

DEVELOPMENTAL HISTORY

Please use back of sheets if more space is needed anywhere on this questionnaire.

I. PRENATAL AND BIRTH HISTORY:

A. Mother's Health During Pregnancy:

A. Infections or illnesses during pregnancy? ☐ Yes ☐ No
If "yes," describe: ____
B. Shocks or unusual stress during pregnancy? ☐ Yes ☐ No
If "yes," describe: ____
C. Water broke more than 24 hours before delivery? ☐ Yes ☐ No
D. Developed toxemia/high blood pressure ☐ Yes ☐ No
At what stage of pregnancy? ____
E. Any complications during labor or delivery? ☐ Yes ☐ No
If "yes," describe: ____
F. Mother's age at delivery ____
G. Number of previous miscarriages? ____

B. Child's Birth

1. Premature? ☐ Yes ☐ No
2. Cesarean Section? ☐ Yes ☐ No
3. Breech Delivery ?(feet first) ☐ Yes ☐ No
4. Face presentation? ☐ Yes ☐ No
5. Transverse? ☐ Yes ☐ No
6. Cord wrapped around neck? ☐ Yes ☐ No
7. Required forceps? ☐ Yes ☐ No
8. Any birth injuries? ☐ Yes ☐ No
Describe ____
9. Had insufficient oxygen? ☐ Yes ☐ No
10. Did not cry right away? ☐ Yes ☐ No

11. Required intensive care or hospitalization? ☐ Yes ☐ No
    a. How long?______________________________
    b. Respiratory problems? ☐ Yes ☐ No
    c. Needed respirator? How long?____ ☐ Yes ☐ No
    d. Small for gestational age? ☐ Yes ☐ No
    e. Heart defect? ☐ Yes ☐ No
    f. Required exchange transfusion? ☐ Yes ☐ No
    g. Jaundiced? How long under lights? __ ☐ Yes ☐ No
    h. Had congenital abnormalities? ☐ Yes ☐ No
    i. Had seizures? ☐ Yes ☐ No
    j. Had infection at birth? ☐ Yes ☐ No
    k. Had surgery as newborn? ☐ Yes ☐ No
       Describe ______________________________
    l. Had feeding problems as a newborn? ☐ Yes ☐ No

12. Length of pregnancy __________ Birth Length ____________________
    Birth Weight ________________ Child's weight at discharge _________
    Apgar Scores ___ 1 minute ___ 5 minute

C. Describe your child as an infant (check all that apply):
___Fussy ___Irritable ___Good ___Non-demanding ___Alert ___Quiet ___Active

D. Describe your child's sleeping patterns:
As an infant: ___Good sleep patterns ___Irregular sleep patterns
Currently: ___Good sleep patterns ___Irregular sleep patterns

E. Describe your child's behavior when held:
As an infant: ___Happy ___Resistant ___Tense ___Floppy
Currently: ___Happy ___Resistant ___Tense ___Floppy

II. Medical History

A. List illnesses and injuries, and the age at which they occurred (i.e. chronic illnesses, asthma, middle ear infections, seizures, allergies, etc.)__________________________
____
____

B. Other Professional Evaluations:

Discipline	Name	Date	Results
Opthomologist	____________________	_____	______________________
Audiologist	____________________	_____	______________________
Neurologist	____________________	_____	______________________
Psychologist	____________________	_____	______________________
Other	____________________	_____	______________________

C. List and give dates of any previous or current therapy programs:

Discipline	Agency	Date	Results
OT	____________________	_____	______________________
PT	____________________	_____	______________________
Speech	____________________	_____	______________________
Music	____________________	_____	______________________
Vision	____________________	_____	______________________

III. Developmental Milestones

As nearly as possible, indicate the age at which your child achieved these milestones. Note if there were any unusual aspects about these milestones for your child. Also, indicate any milestones that have not been met.

A. Motor Skills

Rolled over ______________________________
Sat alone ______________________________
Crawled ______________________________
Pulled to stand ______________________________
Cruised (walked with support) ______________________________
Walked alone ______________________________
Ran ______________________________
Hopped ______________________________
Skipped ______________________________
Managed stairs ______________________________
Rode tricycle ______________________________
Rode bicycle without training wheels ______________________________
Pumped self on swing ______________________________
Threw ball ______________________________
Caught ball ______________________________
Demonstrated a hand preference ______________________________
Interested in coloring ______________________________
Managed scissors ______________________________

B. Feeding/Self Help

Was your child breast or bottle fed? ______________________________
Did your child have any feeding problems? ______________________________
When was solid food introduced and how did this child react? ____________________
____
Is your child on a special diet? ______________________________

At what age did your child do the following:

____Drink from a cup
____Feed self with spoon
____Eat neatly
____Put on t-shirts
____Tie shoes
____Put shoes on correct feet
____Feed self with hands
____Cut with fork & knife
____Put on pants
____Button
____Toilet train

C. Language

At what age did your child:

____Babble ____Speaks single words
____Speak in phrases ____Speaks in sentences
____Converse with you

IV. Family History

A. List ages of other children in the home: ____________________

B. List any family problems which you feel might be affecting your child: ____________________

____

____

C. Is there any family history of learning or motor problems? Please describe: ____________________

____

____

V. Other

A. Tell us what your child's strengths are. ____________________

____

B. What endears your child to you? ____________________

____

C. What does your child like to do for play? ____________________

____

D. Tell us what your child does well. ____________________

____

E. What is the best way to approach your child? ____________________

____

F. Please describe your child's problem(s) as you see them. ____________________

____

G. How do you expect therapy to benefit your child? ____________________

____

H. If there is something that you wish us to know that is not covered in the above portion of this questionnaire? ____________________

____

I. List any adaptive equipment which is used by your child.

____Glasses ____Hearing aids ____Crutches
____Braces ____Wheelchair ____Walker
Other____________________

____
Signature/Date