Registration Form

Client Information

Today's Date: _____ Parent's Email: _____

Child's Name: _____ Sex :_____ Birthday:_____

Full Address: _____

Mother's Name: _____ Mother's Phone: _____

Father's Name: _____ Father's Phone: _____

Insurance Information (please have card available to copy)

Diagnosis:_____

Child's Physician: _____ Referral Date (Office Only): _____

Parent/Guardian 1 Name: _____ Birthday:_____

Social Security: _____ Address: _____

Employer: _____ Employer Phone: _____

Employer Address: _____

Parent/Guardian 2 Name: _____ Birthday:_____

Social Security: _____ Address: _____

Employer: _____ Employer Phone: _____

Employer Address: _____

Primary Insurance Subscribers Name: _____

Group No: _____ Policy No: _____ Co-Payment: _____

Secondary Insurance Subscribers Name: _____

Group No: _____ Policy No: _____ Co-Payment: _____

I adhere that the information provided is true to the best of my knowledge. I authorize Idaho Therapy Source, PLLC and/or my insurance provider to release any information that is required to process my claims. I understand that my insurance benefits are paid directly to the clinic. I understand that I am responsible for any outstanding balances to Idaho Therapy Source, PLLC including co-payments and percentages; I understand per Idaho law that co-payments cannot be waived for any circumstances. Please confirm and understand your benefit plan with your provider and understand that some diagnoses/therapy may not be covered by your insurance.

Parent/Guardian Signature: _____ **Date:** _____

CONTINUE ON BACK

Background Information

Today's Date: _____ Child's Full Name: _____

Gender & Age of Siblings Living in Home: _____

_____

School Attending: _____ Grade/Level: _____

Teacher's Name: _____ School Phone Number: _____

Issues of Concern at Home/School: _____

_____

Complications/Illness/Infections/Stress During Pregnancy: Y/N (If Yes, Describe):

_____

Forceps/Vacuum/C-Section? Y/N (If Yes, Describe): _____

Birth Order: _____ Birth Weight: _____ Post/Premature/Full Term: _____

Breast Fed? Y/N (How Long?): _____ Strong Suck? Y/N Spit Up Often? Y/N

Problems with Feeding/Respiration/Sleeping: _____

Irritable/Happy/Quiet (circle best) Baby?

Did Baby Arch Back & Head When Upset/Frustrated? Y/N

Developmental Milestones: Note Approximate Age:

Rolled: _____ Sat: _____ Belly Crawled: _____ Crawled: _____

Cruised: _____ Walked: _____ Said First Words: _____ Talked: _____

Potty Trained: (Bladder) _____ (Bowels) _____Undressed Self: _____

Dressed Self: _____ Managed Snaps/Zippers/Buttons: _____ Tied Shoes: _____

Started Pre-School: _____ Preferred Hand L/R Age Established_____

General Health Questions:

Ear Infections? Y/N (Number/Ages) _____ Seizures? Y/N (Describe) _____

Known Allergies? Y/N (Describe) _____ Injuries? Y/N (Describe) _____

Hospitalizations? Y/N (Describe) _____ Glasses? Y/N (Condition) _____

Medications? Y/N (List) _____

_____

In Case of Emergency (non-parent preferred)

Name: _____ Relationship: _____ Phone: _____