Idaho Therapy Source

16171 N Brinson St
Nampa, ID 83687
Phone: (208) 442-2525
Fax: (208) 442-2505

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please Print)					
LAST NAME:	FIRST:	MI:	DOB:	AGE:	SEX: M F
STREET ADDRESS:	CITY:	STATE	ZIP CODE		
PRIMARY CARE DR. & ADDRESS:	PRIMARY DR. PHONE & FAX NUMBERS:				
DIAGNOSIS:					

PARENT/GUARDIAN & INSURANCE INFORMATION (please have insurance card available for us to copy)			
PARENT/GUARDIAN 1 NAME:	BIRTHDAY:	SSN:	PRIMARY PHONE:
EMPLOYER:	EMPLOYER PHONE:	EMPLOYER ADDRESS:	
PARENT/GUARDIAN 2 NAME:	BIRTHDAY:	SSN:	PRIMARY PHONE:
EMPLOYER:	EMPLOYER PHONE:	EMPLOYER ADDRESS:	

PRIMARY INSURANCE SUBSCRIBERS NAME:	GROUP #	POLICY #
SECONDARY INSURANCE SUBSCRIBERS NAME:	GROUP #	POLICY #
PARENT/GUARDIAN 1 EMAIL:	PARENT/GUARDIAN 2 EMAIL:	
IN CASE OF EMERGENCY (Non-parent) NAME & RELATIONSHIP:	PHONE:	
HOW DID YOU HEAR ABOUT IDAHO THERAPY SOURCE:		

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: _____

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PATIENT MEDICAL HISTORY

NAME OF PATIENT: (FIRST & LAST)			DATE:
SCHOOL CURRENTLY ATTENDING:			
GRADE LEVEL:	TEACHERS NAME:	SCHOOL PHONE # AND FAX #:	
ISSUES OF CONCERN AT HOME/SCHOOL:			
GENDER & AGE OF IN-HOME SIBLINGS:			
COMPLICATIONS/ILLNESS/INFECTIONS/STRESS DURING PREGNANCY? Y/N (If Yes, Describe)			
FORCEPTS/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:			
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 PRESCHOOL:
ESTABLISHED DOMINATE HAND: L/R			
GENERAL HEALTH QUESTIONS (Note Approximate Age)			
EAR INFECTIONS? Y/N (NUMBER/AGES)		SEIZURES? Y/N (Describe)	
KNOWN ALLERGIES? Y/N (Describe)		INJURIES? Y/N (Describe)	
HOSPITILIZATIONS? Y/N (Describe)		GLASSES? Y/N (Describe)	
SURGURIES? (Describe)			

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AREAS OF CONCERN & GOALS

NAME OF PATIENT: (FIRST & LAST)	DATE:

MY PRIMARY AREA(S) OF CONCERN AT THIS TIME IS (CHECK ALL THAT APPLY)

- ☐ FEEDING/DIETARY
- ☐ SENSORY
- ☐ SPEECH/LANGUAGE
- ☐ SOCIAL/EMOTIONAL
- ☐ MOTOR COORDINATION / FINE & GROSS MOTOR
- ☐ ADLS (I.E., DRESSING, BATHING, TOILETING, ETC.)

PLEASE DESCRIBE IN YOUR OWN WORDS, WHAT YOUR CURRENT CONCERNS FOR YOUR CHILD AT THIS TIME (I.E., RELATED TO ACADEMICS, ACTIVITIES OF DAILY LIVING, RELATIONSHIPS, SENSORY, SPEECH, MOTOR, PLAY, FEEDING):

HOW CAN WE BE MOST HELPFUL TO YOU AND YOUR CHILD?

WHAT ARE YOUR GOALS FOR YOUR CHILD'S PROGRAM? PLEASE BE A SPECIFIC AS POSSIBLE:

GOAL 1:

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NAME OF PATIENT: (FIRST & LAST)	DATE:

GOAL 2:

GOAL 3:

GOAL 4:

GOAL 5: