Welcome! Thank you for selecting our practice. In order to serve you properly, we will need the following information. All information will be kept strictly confidential. **(Please print)**

Patient Name: _____

Street: _____ City: _____

State (Prov.) _____ Country _____ Zip (Postal Code) _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Date of Birth _____/_____/_____

Single ____ Married _____ Divorced _____ Separated _____ Widowed _____ Partnered _____

If child, Parent/Guardian's Name: _____

Employer: _____ Occupation: _____

Address: _____

Family Physician: _____

Physician Address: _____

Physician Phone: _____

In case of emergency, please provide us with the name of the nearest relative not residing with you:

Name: _____ Phone: _____

Relationship: _____

I understand that payment is expected at the time of service, I am responsible for all charges/fees regardless of insurance coverage. I also understand that Dr. Giammatteo, DC PT, IMTC, is a non-participating Medicare provider and payment is expected at time of service.

Patient/Guardian Signature: _____ Date: _____

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize_____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐_____ to _____.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or personal representative

_____

Printed name of patient or personal representative and his or her relationship to patient

Date _____

Pediatric: Parent Questionnaire

Dear Parent or Guardian: We appreciate your time and care in completing this questionnaire. We are aware of its lengthy nature, however, the significance of all of the information cannot be stressed enough. Your diligence with answering will greatly add to our ability to help your child meet their/your goals. Please print clearly in blue or black ink. Please have this form completed in full prior to the child's initial evaluation. Please have this questionnaire available for the IMT practitioner privileged with doing the initial intake on your child. Thank you!

Child's Name _____ _____ ___ _____

LAST FIRST M.I. NICKNAME

Date of Child's Birth: _____
Date Questionnaire Complete: _____
Person Completing Questionnaire: _____
Relationship to Child: _____

Intervention Team

Dear Parent, please list all persons participating in your child's care. Please place a checkmark in front of the persons to whom you are requesting an evaluation result to be sent. Thank you!

Referral from: _____ (DC, DO, MD)
Address _____ Phone#: _____

Other: _____ (DC, DO, MD)
Address _____ Phone #: _____
Other: _____ (DC, DO, MD)
Address _____ Phone #: _____
Other: _____ (DC, DO, MD)
Address _____ Phone #: _____
Other: _____ (DC, DO, MD)
Address _____ Phone #: _____

Signature _____ Date _____

CONSENT TO TREAT and TOUCH of MINOR

I (We) being the parent or guardian of _____, a minor, the age of _____ do hereby consent, authorize and request Dr. _____ to administer such treatment deemed advisable, necessary or requested on the above minor.

I (We) agree to hold him free and harmless from any claims, suits for damages or complications which may result from such treatment.

Signed _____
Parent or Guardian

Date _____

Witness _____

12 North Main Street, Suite 30, West Hartford, CT 06107 Telephone (860) 561 2286

CHILD'S NAME _____ DOB _____

Diagnoses:

Dear Parent, please record all diagnoses that your child has been given and provide further details in the space provided. Thank you!

_____
_____
_____
_____
_____
_____
_____

CHILD'S NAME _____ DOB _____

Pregnancy/Delivery History:

Dear Parent, please circle historical data and provide added details in space provided. Thank you!

Mother: Cigarettes Alcohol Drugs _____ Infections _____
Complications: _____
Father: Cigarettes Alcohol Drugs _____ Infections _____
Complications: _____
Labor: Home _____ Hours _____ / Hospital _____ Hours Total Hours _____
Induction Drugs _____ Complications _____
Delivery: Natural Cesarean Vaginal Forceps Vacuum
Anesthesia _____ Complications _____
Country: USA Canada Other _____
Apgar Scores: _____ Weight _____ Length _____
Immediate Hospitalization: NICU _____ Hours/Days/Months
Nursery _____ Hours/Days/Months
Complications _____
Adopted at Age _____months.
Other:

_____
_____
_____
_____
_____

CHILD'S NAME _____ DOB _____

Medical History

Dear Parent, please give an accounting of your child's medical history with ages. Thank you!

Hospitalizations/Surgeries:_____

_____

_____

Infections:_____

_____

Fractures: _____

_____

Seizures: _____

_____

Other Injuries: _____

_____

Other Complications: _____

_____

Dental: _____

_____

Immunizations:

Dear Parent, the "X" signifies the immunization schedule recommended by the American Academy of Pediatrics. Please check the boxes of the vaccinations you child has had. Use the space below for varied information. Thank you!

INDEX: HB = Hepatitis B DPT = Diphtheria, Pertussis & Tetanus
HiB = Hemophilus B OPV = Polio
VZ = Varicella Zoster MMR = Measles, Mumps and Rubella (German measles)

	Months					Years			
Immunization	**0-2**	**2**	**2-4**	**4**	**6**	**6-18**	**12-15**	**12-18**	**3 & over**
HB	X		X			X			
DPT		X		X	X			X	
HiB		X		X	X		X		
OPV		X		X		X			
VZ								X	
MMR							X		

Other: _____

CHILD'S NAME _____ DOB _____

Medication History:

Dear Parent, please list all medications your child has taken and the goal for taking the medication. Thank you!

MEDICATION DOSAGE GOAL

Currently taking:

_____

_____

_____

Others in Past Year:

_____

_____

_____

Prior Years:

_____

_____

_____

Nutritional Supplements:

_____

_____

_____

Bracing/Positioners:

Dear Parent, please record all braces, positioners and assistive devices. Please provide time and frequency of use, as well as the intended purpose of the device. Thank you!

Device Time/Frequency Purpose

_____

_____

_____

_____

_____

_____

_____

CHILD'S NAME _____ DOB _____

Sleeping Patterns:

Dear Parents, please circle your child's preferred sleeping position and patterns. Thank you!

Deep sleeper Light sleeper Fussy sleeper Wakes frequently Cries frequently
On back On abdomen On left side On right side All positions
Restless Other: _____
Your child's average number of hours of sleep per nighttime _____ per day time _____

Social/Emotional:

Dear Parent, please list primary persons in your child's life with relationship and ages. Place a check mark in from of behaviors that your child has demonstrated. Thank you!

Parents:_____
Siblings: _____
Others: _____

___ Makes eye contact
___ Smiles often
___ Vocalizes to socialize
___ Interested in other Children
___ Shows anticipation
___ Shows humor
___ Explores surroundings
___ Manipulates objects social interactions
___ Watches self in mirror
___ Anxiety with strangers
___ Seeks approval of parents
___ Understands "NO"
___ Gives hugs
___ Possessive of toys
___ Shows self-awareness
___ Plays with others
___ Entertains self
___ Tantrums

Sensory:
Dear Parent, please circle L (likes) or D (dislikes) or I (Indifferent). Thank you!

L	D	I	Hugs	L	D	I	Sand boxes
L	D	I	Stroking	L	D	I	Swings
L	D	I	Bathing	L	D	I	Slides
L	D	I	Hair combing/brushing	L	D	I	Warm water (bathing)
L	D	I	Teeth brushing	L	D	I	Cool water (bathing)
L	D	I	Tags on clothes	L	D	I	Fitted clothes
L	D	I	Finger painting	L	D	I	Quiet
L	D	I	Tickles	L	D	I	Loud sounds
L	D	I	Surprises	L	D	I	_____

CHILD'S NAME _____ DOB _____

Pain:

Dear Parent, please describe areas of the body that your child complains of pain, range of pain on a 0-10 scale, and any related time or activity that increases the pain. Thank you!

LOCATION RANGE TIME/ACTIVITY INCREASING THE PAIN

_____

_____

_____

_____

_____

Motor Development:

Dear Parent, please place a check mark in front of behaviors that your child has demonstrated or currently does demonstrate. If behavior relates to a left or a right side, please indicate by circling the L or the R, or Both. Thank you!

INDEX: Prone = Lying on abdomen Supine = Lying on back

	Prone – lifts head	
	Prone – props on elbows	
	Prone – Props on straight arms	
	Hands to mouth	L R Both
	Hands together	
	Hands to feet	L R Both
	Holds objects	L R Both
	Reaches for objects	L R Both
	Lets go of objects	L R Both
	Rolls prone to supine	
	Rolls supine to prone	
	Achieves sitting independently	
	Sits without support	
	Assumes hands and feet	
	Rocks on Hands and Knees	
	Passes object from one hand to other	
	Picks up small objects	L R Both
	Crawls on belly	
	Crawls on hands and knees	
	Pulls to kneeling	

CHILD'S NAME _____ DOB _____

	Pulls to standing	
	Squats	
	Plays Peek-a-boo	
	Stands alone for how long? Sec/min/hour	
	Walks along furniture	
	Walks holding one hand	
	Stoops to pick up object	
	Walks alone	
	Climbs furniture	
	Climbs stairs	
	Waves bye bye	L R Both
	Walks up stairs	
	Builds a tower of cubes/objects 3 4 5 6	
	Stands on one foot	
	Hops	
	Skips	
	Rides bike	
	Kicks ball in standing	L R Both
	Throws objects	L R Both

Other:

_____

_____

_____

_____

_____

_____

12 North Main Street, Suite 30, West Hartford, CT 06107 Telephone (860) 561 2286

CHILD'S NAME _____ DOB _____

Bowel and Bladder:

Dear Parent, please place a check mark in front of the representative behaviors for your child. Circle time of day and fill other information requested. Thank you!

_____Wears diapers a.m. p.m.
_____Wears pull-ups a.m. p.m.
_____Wears regular underwear a.m. p.m.
Urinates _____ times per day.
Bowel movement _____ times per day.
Consistency is typically stone-like firm soft and formed loose liquid
Uses toilet successfully _____ % of the day for urinating
Uses toilet successfully _____ % of the day for bowel movements

Communication/Hearing:

Dear parent, please place a check mark in front of behaviors that your child has demonstrated or currently does demonstrate. If behavior relates to a left or a right side, please indicate by circling the L or the R or both. Thank you!

	Coos		Memory of past day		Articulation difficulties
	Smiles		Memory of past week		Slurring
	Laughs		Turns toward voices		Stuttering
	Clicks		Startles to loud noises		Processing delay
	Mmm		Mimics sounds		Uses pacifier
	Ddd		Enjoys voice play		
	Nnn		Enjoys sound toys		
	Bbb		Pulls on ear R L		
	Fff		No ear infections		
	Sss		1-3 ear infections per yr.		
	Ggg		More than 3 ear infections R L		
	1-15 words		Tubes in ears R L		
	More than 15 words		Hearing aids R L		
	More than 100 words		Beginning sign Lang.		
	2 word phrases		Advanced sign Lang.		
	3 word phrases		Communication board		
	4 word phrases		Augmentative device		
	Unlimited phrase length		Receptive difficulties		
	Memory of past hour		Expressive difficulties		

CHILD'S NAME _____ DOB _____

Dietary:

Dear Parent, please check and circle your child's food intake information. Thank you!

_____Unlimited intake capability
_____Tube fed – nasal GI Tract _____ Location
_____Breast fed
_____Breast milk by bottle and/or cup
_____Formula Type _____
_____Baby foods Types _____
_____Pureed foods Types _____
_____Mixed foods Types _____

Goals:

Dear Parents, please list the goals you have for your child's next 6 weeks, next 6 months and so on. Thank you!

6 Weeks:
1. _____
2. _____
3. _____
4. _____
5. _____

6 Months:
1. _____
2. _____
3. _____
4. _____
5. _____

1 Year:
1. _____
2. _____
3. _____
4. _____
5. _____

2 Years:
1. _____
2. _____
3. _____
4. _____
5. _____

3 Years:
1. _____
2. _____
3. _____
4. _____
5. _____

4 Years:
1. _____
2. _____
3. _____
4. _____
5. _____