NELA REHABILITATION
204 Boots Drive Farmerville, LA 71241
Phone: (318) 620-0075 Fax: (318) 620-0070
www.nelarehab.com

Helping you learn to live beyond your current bounds.

PATIENT INFORMATION – PEDIATRIC

Patient Name: _____ Preferred Name: _____

Address: _____ City: _____ State:_____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ D.O.B. _____ Gender: Male Female

School Name: _____

RESPONSIBLE PARTY

Name: _____

Address: _____

_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

D.O.B.: _____

Social Security: _____

Email: _____

Employer: _____

Relationship to Patient: Mother Father Guardian

INSURANCE INFORMATION

Name of Insurance Company: _____

Name of Policy Holder: _____

Policy Holder Address: _____

_____

Home Phone: _____

Work Phone: _____ Cell Phone: _____

D.O.B.: _____ SS#: _____

Employer: _____

Policy Holder ID: _____

Group #: _____

Relationship to Patient: Mother Father Guardian

EMERGENCY/ALTERNATE CONTACT NUMBERS

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

How did you hear about us? ☐ Word of Mouth ☐ Physician Reference ☐ Advertizing

☐ Search Engine ☐ Insurance Provider List

Assignment of Insurance Benefits: I hereby authorize Northeast Louisiana Rehabilitation, LLC to provide any medical care that is deemed necessary. I hereby authorize payment of benefits directly to Northeast Louisiana Rehabilitation, LLC. I hereby authorize Northeast Louisiana Rehabilitation, LLC to release any information necessary to process my claim. I acknowledge/understand that I am responsible for any charges incurred that my insurance does not pay for or cover for any reason whatsoever. I also acknowledge that if my account is turned over to a collection agency that I will be responsible for the collection fee towards my account. I also attest that the information that I have provided above is correct and truthful to the best of my knowledge.

Patient/Guardian's Signature: _____ Date: _____

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PEDIATRIC INTAKE FORM

Child's Name: _____

Current Diagnosis: _____

Person filling out this form and relationship to child: _____

REASON FOR REFERRAL:

What are your primary areas of concern / What are you hoping for the therapist to address?

_____

_____

_____

_____

Please describe the major concerns and / or goals you have in seeking help for your child. List concerns in order to their importance to you.

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICAL HISTORY

Item	No	Yes	Description	Explanation
1			Asthma	
2			Allergies	If yes, please list:
3			Bronchitis	
4			Chicken Pox	
5			Chronic Colds	
6			Chronic Ear Infections	
7			Hay Fever	
8			Seizures	
9			High Fevers	
10			Draining Ear (tubes)	
11			Tonsillectomy	
12			Meningitis	

Item	No	Yes	Description	Explanation
13			Kidney Disease	
14			Convulsions	
15			Muscle Disorder	
16			Hear Condition	
17			Hormonal Issues	
18			Joint / Bone Problems	
19			Visual Disorder / Vision Problems	
20			Eye Infections	
21			Vomiting / Digestion Problems	
22			Failure to Gain Weight	
23			Hearing Loss / Ear Disorder	
24			Ingestion of toxins, poisons, foreign objects	

Has your child had any difficulties with feeding (i.e. sucking, swallowing, drooling, chewing, choking)? If yes, please describe._____

_____

_____

Hospitalizations / Surgeries includes approximate dates: _____

_____

_____

Please list all medications the child is currently taking: _____

_____

_____

PRENATAL AND BIRTH HISTORY

Please list any significant prenatal or birth history (weeks gestation, birth weight, APGARS). _____

_____

_____

_____

Check all that apply

Premature		Full Term	
Low Birth Weight		IUGR	
Weeks Gestation		Breech Birth	
C-Section Birth (Planned)		Emergency C-Section	
Vaginal Birth		Forceps Delivery	
Preeclampsia		Gestational Diabetes	
Breast Fed		Poor Suction / Latch	
Bottle Fed		Multiple Ultrasounds	
Oxygen at Birth		NICU Stay and Duration	
Other:			

DEVELOPMENTAL HISTORY

Fill in the blanks to describe your child to the best of your ability:

Milestones	Age
Sat at	_____ months / years
Crawled at	_____ months / years
Stood at	_____ months / years
Walked at	_____ months / years
Ran at	_____ months / years
Talked at	_____ months / years
Dressed at	_____ months / years
Toilet Trained at	_____ months / years
Fed self at	_____ months / years

___ Was not placed on his / her belly as an infant
___ Enjoyed belly time as an infant
___ Did not tolerate being placed on his / her belly as an infant
___ Met all motor milestones on time
___ Was / is developmentally delayed
___ Is clumsy

___ Was placed on his / her belly as an infant
___ Is athletic / plays sports
___ Is good negotiating playground equipment
___ Is good with her / her hands (fine motor)
___ Was late to _____
___ Avoids climbing, swinging, sliding

Please list any motor development concerns you have (i.e. gross motor, fine motor, oral motor, motor planning, fear of movement, fear of heights, ect.) _____
_____
_____

ACADEMIC HISTORY

Check all that apply to your child:

___ Does well in school
___ Does well with the exception of _____
___ Is challenged by school
___ Is challenged by writing
___ Is challenged by reading
___ Is not enrolled in school
___ Receives resource / tutoring for _____
___ Is an A B C D F student (please circle one)
___ Is in a self-contained classroom

Please list any academic concerns that you have. _____
_____
_____

Please list any specific teacher concerns. _____

_____

BEHAVIORAL / SOCIAL HISTORY

Check all that apply to your child

___ Is social and engaging	___ Does not like new places
___ Makes good eye contact	___ Does not like crows
___ Is well behaved	___ Has difficulty with transitions
___ Pays attention	___ Prefers to play alone
___ Listens well	___ Has difficulty paying attention
___ Follows directions well	___ Is very busy and active
___ Plays well with other children	___ Poor coping skills
___ Is easy going	___ Unable to self-calm
___ Does well with change	___ Extremely sensitive to criticism
___ Understands safety	___ Quickly escalates without apparent cause
___ Takes turns with peers	___ Has tantrums
___ Is aggressive	___ Is oppositional

Please list any behavioral or social concerns. _____

_____

_____

My signature below is confirmation that I have informed Northeast Louisiana Rehabilitation of all necessary information and have answered all questions truthfully and to the best of my ability.

_____ _____

Parent / Guardian Signature *Date*

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Medical History Questionnaire

What is your main reason for needing therapy?

_____

When and how did this begin? _____

_____

What imaging (ie. Xray, MRI, CT) have been performed? Include date and results if known.

_____

Are you currently working? _____ YES _____ NO Occupation? _____

In what type of recreational activities do you participate? _____

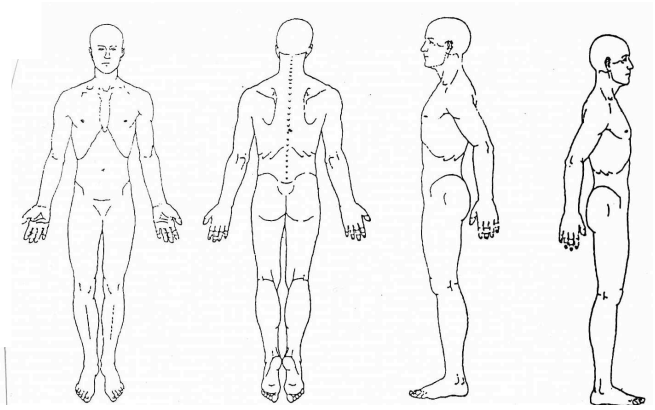
Do you smoke? _____ YES _____ NO

When is your next appointment with referring MD? _____

Any scheduled appointments with other doctors? _____

Primary Care Physician's Name and Clinic: _____

****Please Shade in Specific Areas of Pain on the Diagrams****



Rate your pain on a scale of 0-10 (0 = no pain and 10 = emergency room pain)

____/10 right now

____/10 at its worst

____/10 at its best

Please list all Current Medications, dosages, and frequency (or provide a list to be copied):

Name and Purpose	Dosage	Frequency	Route

Please list all current medical conditions (ie. Diabetes, High Blood Pressure, Heart Conditions, etc.) and all previous surgeries and dates:
