Ability Physical Therapy PLLC
PH: (406) 502-1210
Fax: (406) 205-4423
AbilityPT@icloud.com

1225 Birch Street Suite B
P.O. Box 4181
Helena, MT 59604
Web: Abilitypt.org

Please fill out this form as completely as possible.

Client & Guardian Demographics:

Today's date: ___/___/_____
Child's name: _____ DOB: ___/___/_____
Mother's/Guardian's name: _____ Phone: (___)___-_____
Father's/Guardian's name: _____ Phone: (___)___-_____
Address: _____ City: _____ State: _____
Can we leave messages on your home/mobile phone(s)? ☐ Yes ☐ No
Can we text your mobile phone regarding upcoming appointments? ☐ Yes ☐ No

Insurance Information:

Primary Insurance Provider: _____ Phone number: _____
Insurance ID number: _____ Group number: _____
Policy Holder: _____ Policy Holder DOB: _____

Secondary Insurance Provider: _____ Phone number: _____
Insurance ID number: _____ Group number: _____
Policy Holder: _____ Policy Holder DOB: _____

Primary Care Provider (PCP): _____ Phone: (____)_____-_____
Do you have a prescription/referral: ☐ Yes ☐ No
Referring physician: _____ Phone: (____)_____-_____

Current concerns regarding motor development:

Has your child ever received therapy before? If yes, please explain: _____
_____
What concerns do you have regarding your child's development? _____
_____
Has your child been diagnosed with a medical condition? If yes, please explain: _____
_____
When was the diagnosis first made? _____

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Birth History:
Birth weight: _____ Birth length: _____
Was prenatal care received? ☐ Yes ☐ No
Length of pregnancy: _____
Complications during pregnancy (check any that apply):
☐Diabetes ☐Measles ☐Strep ☐Toxemia (Preeclampsia) ☐Other: _____
Delivery method:
☐Vaginal: ☐Induction ☐Forceps ☐Vacuum Extraction
☐Cesarean: ☐Emergency
Describe any delivery complications: _____
_____
Child's condition after birth: ☐Premature? How much:_____ Apgar: _____
☐NICU ☐Jaundice ☐Heart problems ☐Ventilator? How long: ____ ☐Poor suck
☐Other: _____

Medical History:
Check any that apply: ☐Low birth weight ☐Measles ☐Mumps ☐Pneumonia ☐Chicken Pox ☐Bronchitis
☐Gastric Reflux ☐Head Injuries ☐Tonsillitis
☐Hyperactivity/ADD ☐Seizure disorder ☐Asthma ☐Diabetes
☐Ear Infections? How many: _____ Date of last ear infection:_____
Treatment Method: _____
☐Sleep Concerns? Please explain: _____
☐ Allergies? Please list: _____
☐Hospitalizations? (please include dates and reason for hospitalization): _____
_____
Please list any surgeries: _____
Please list any medications and dosages (prescribed and over-the-counter): _____
_____
Are immunizations current? ☐ Yes ☐ No
Has your child had a vision test? ☐ Yes When _____ Results _____ ☐ No
Has your child had a hearing test? ☐ Yes When ____ Results _____ ☐ No
Does your child wear a hearing aide? ☐ Yes ☐ No ☐ Right ☐ Left
Is your child followed by a specialist? ☐ Yes Name: _____ ☐ No
Pertinent family history: _____

Motor Development:
At what age did your child accomplish the following:
Roll over _____ Sit unsupported _____ Crawl _____ Walk _____
Do you have any concerns regarding the following (check all that apply):
☐Ability to lift head against gravity ☐Bring hands to midline
☐Reach for objects ☐Pull to sit or stand
☐Run ☐Jump/hop
☐Balance on one foot ☐Manage stairs

Does your child need adaptive equipment? ☐ Yes Type: _____ ☐ No

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School Information:
School (or daycare) attending: _____Phone: (____)_____-_____
Does your child currently have an IEP or IFSP? ☐ Yes ☐ No

Emergency Contact Information:
Name: _____ Relation: _____
Phone: (____)_____-_____

Other:
Any additional information or concerns you may have: _____
_____
Goal(s) you have for your child regarding physical therapy: _____
_____

Waiver:

I, _____the parent or guardian of _____(hereafter referred to as "my child") give permission for my child to participate in Ability Physical Therapy, PLLC programs and services. I hereby release Ability Physical Therapy, PLLC, owner, therapists, employees, and other representatives from any and all claims which I or my child may have, resulting form or in connection with my child's participation in Ability Physical Therapy's programs. This includes, but is not limited to any claim, demands or causes of action for injuries to my child including but not limited to injuries resulting from the use of any play/therapy equipment during the program.
I understand that I am required by Ability Physical Therapy, PLLC to be present at all times during the delivery of service to my child. If I chose not to, I understand that the aforementioned statements sill apply in my presence or absence during the services provided. This agreement is signed for the purpose of fully and completely releasing, discharging and indemnifying Ability Physical Therapy, PLLC.

_____ _____
Guardian's Signature Date