Welcome to Our Program

Hello and welcome to Inova Loudoun Rehabilitation Center’s Feeding and Swallowing Center at Lansdowne. We are happy that you have chosen our program to address your child’s feeding and/or swallowing needs. Our mission is to evaluate and treat a spectrum of feeding aversions, disorders, and swallowing problems experienced by infants and children on an outpatient basis.

We are very fortunate to have a number of professionals from a variety of backgrounds that are either on staff here at our facility or whom we work very closely with from other offices. The main goal of our program is to evaluate and treat your child as an individual, rather than only looking at the feeding and/or swallowing problem as a separate issue. Often a feeding or swallowing problem is the result of one or more factors and is not simply a behavioral issue in that your child just does not want to eat. This is why we feel that it is very important to look at the whole child, and to use our skills and knowledge for ongoing evaluation and problem solving throughout the therapy process. We do not use one specific therapy approach. We use the approach that works best for your child and your family. As a result, we are able to achieve success with a wide variety of children who have a wide variety of diagnoses including food refusals, gastroesophageal reflux disease (GERD), oral aversions, poor weight gain, failure to thrive, oral motor problems, sensory integration dysfunction, pharyngeal dysphagia, and children with feeding tubes.

The rehab team at our feeding and swallowing center is comprised of pediatric therapists who are used to a variety of personalities, behaviors, nap schedules and daycare or school situations. We realize that being flexible is a must when working with children.

We are very excited about the work that we do and we hope that it shows in our evaluations and therapy sessions. Feeding problems can be very serious and are often times very stressful on the entire family. We realize this and we strive to meet the needs of your child as well as your family’s needs throughout the therapy process. Please feel free to voice any concerns to us or our office staff at any time.

We look forward to seeing you in our kitchen!

The Pediatric Rehabilitation staff
Pediatric Feeding & Swallowing Center
Intake Form

**Biographical**
Child's Name: _______________________ Sex: M/F Date of Birth: ____________

Parents Name- Mother: ___________ Father:_______________________________

Address: __________________________ City, State, Zip: ______________________________

Home Phone: _________________ Cell: ______________________________

Other Caregivers (i.e. nanny, daycare provider, etc): _____________________________________
________________________________________________________________________________________

Siblings (name & age): _________________________________________________________________

**Feeding Issues**
What is your major feeding concern? Please describe feeding problem.
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

What is your feeding goal(s) for your child?
____________________________________________________________________________________________
____________________________________________________________________________________________

**Medical Team**
Name of Primary Care Physician/Pediatrician: ______________________________________
Address: ___________________________________________________________________________
Phone: ______________________________ Fax: ________________________________________

Name of Gastroenterologist: ________________________________________________________
Address: ___________________________________________________________________________
Phone: ______________________________ Fax: ________________________________________

Please list any other specialists who are treating your child:
Name: _____________________________________________________________________________
Address: ___________________________________________________________________________
Phone: ______________________________ Fax: ________________________________________
Name: _____________________________________________________________________________
Address: ___________________________________________________________________________
Phone: ______________________________ Fax: ________________________________________

Is your child participating in an Early Intervention Program? Y/N
If yes, please list therapists involved (i.e. SLP, OT, PT, nutritionist, etc):
Name: _______________________________ Title: __________________________________
Name: _______________________________ Title: __________________________________
Name: _______________________________ Title: __________________________________
Medical Information
Medical Diagnoses: ______________________________________________________________________
__________________________________________________________________________________________
Pregnancy details: Full term/Premature Vaginal/C-Section

Assisted Birth: N/Y- Forceps/Vacuum  Apgar Scores (if known): ______________

Complications during pregnancy or during/following delivery: No/Yes ______________
__________________________________________________________________________________________

Respiratory/Nutritional support: No/Yes ______________

Feeding tube? No/Yes  (If yes, please complete additional Tube Feeding Intake Form).
If yes, describe: ________________________________________________________________

Overall Development: Normal/Delayed. If delayed, what areas? __________________________
__________________________________________________________________________________________

Hospitalizations (month/year & reason): __________________________________________________
__________________________________________________________________________________________

Current Health: Well/Frequent illness (Please circle any that apply):

- Ear Infections
- Eczema
- Seizures
- Pneumonia
- Irritability
- Rotavirus
- Upper Respiratory Infections
- Aspiration
- Other

Current Weight: ______________  Current Length/Height: ____________

Medications (name, dose): ________________________________________________________________
__________________________________________________________________________________________

Vitamin supplement? N/Y  Please list kind: ____________________ Frequency: ______________

Please check if your child has had the procedures below:

- Swallow Study (MBSS/ OPMS)  Date: _______  Results: ______________
- Endoscopy  Date: _______  Results: ______________
- Gastric Emptying  Date: _______  Results: ______________
- pH probe  Date: _______  Results: ______________
- Upper GI  Date: _______  Results: ______________
- Allergy Testing
  - Skin Test  Date: _______  Results: ______________
  - Blood Test  Date: _______  Results: ______________

Describe any special diet or food intolerance: _______________________________________________
__________________________________________________________________________________________

Bowel Habits:

- Frequency of Bowel Movements _____ times per day/week (circle one).
- Consistency: ___________________  Mucous/ Blood

Feeding History
Breast? N/Y  If yes, at what age was your child weaned? NA/Age ______________

If currently breastfeeding, please describe schedule __________________________________________

Bottle fed : N/Y  Breast milk/Formula?  Current formula: ___________________________

Formula type: Powder/Concentrate/Ready-to-feed  Please describe how you prepare (i.e. 4
oz water, 2 scoops powder): ________________________________________________
__________________________________________________________________________________________
List any previous formulas & describe tolerance: ________________________________________________
__________________________________________________________________________________________
Other fluids presented in bottle: ____________________________________________________________
Solids: at what age where cereals/ baby foods introduced? ________ Any problems? ________________
__________________________________________________________________________________________
Please circle the Stages of baby food that your child ate/eats: 1st/2nd/3rd/Toddler/DICES
Any problems? ____________________________________________________________________________
When were table foods introduced? ______________ Any problems? ________________
__________________________________________________________________________________________
Does your child have any of the following? Please indicate when problem started.
Food Refusal (refusing all or most foods). Age started: __________
Food Selectivity by texture (eating only textures that are NOT age appropriate
Age started: __________
Food Selectivity by Type (eating a limited variety of foods. Age started: ______
Oral motor delays (problems with chewing, etc). Age started: __________
Dysphagia (problems with swallowing). Age started: ____________
Abnormal preferences (temperature sensitive, color specific, particular brands). Please describe:
Other feeding problems: ________________________________________________________________

**Current Meal Pattern**
Which meal is your child’s best? ________________  Worst? ______________________
How long does a ‘typical’ meal take? ______________________________________________________
Please List preferred foods: _________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
Please list non-preferred foods: __________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
Please indicate your child’s typical meal schedule.  Number of meals/snacks:
Timing of meals/snacks: ______________________
Describe sequence in which food/liquids are offered (i.e. liquids first): __________________________
**Feeding Behavior**
Does your child experience any of the following with feeding? N/Y

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Yes/No</th>
<th>Behavior</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choking</td>
<td>Yes/No</td>
<td>Difficulty Chewing</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Gagging</td>
<td>Yes/No</td>
<td>Coughing</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Yes/No</td>
<td>Overstuffs mouth</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Drooling</td>
<td>Yes/No</td>
<td>Teeth Grinding</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Hypersensitive</td>
<td>Yes/No</td>
<td>Penetration/Aspiration</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Sweating</td>
<td>Yes/No</td>
<td>Problem with biting</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

Other_______________________________________________________________________________________

**Feeding Behavior**
Does your child exhibit any of these behaviors at mealtimes? N/Y Circle all that apply.

- Cries or screams
- Messy
- Refuses to Self-feed
- Spits food out
- Throws food
- Eats to fast/slow
- Plays with food
- Picky Eater
- Pushes food away
- Does not suck
- Refuses to swallow
- Induces Vomiting
- Leaves table
- Wants 'down'
- Refuses to open mouth
- Eats non-food items
- Clenches lips shut
- Turns away from spoon

Other: ____________________________________________________________________________________

Do you think your child feels hunger? Yes/No

How does your child indicate hunger? _______________________________________________________

What do you do if your child refuses to eat/drink? ___________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

**Feeding Practices**
Who feeds your child? ______________________________________________________________________

Does your child eat better for a particular feeder? N/Y   Who? ________________________________

Where does your child currently eat (circle all that apply):

- Adult’s Lap
- Infant seat
- High chair
- Booster
- Table/Chair
- Sofa
- Crib/Bed
- Car seat
- Modified Chair
- Wheel chair
- Tumble form
- Roaming- Kitchen/other rooms in the house   Other :______________________________

5
What feeding techniques do you use with your child to get him/her to eat? Please circle.

Coax  Distract with TV/toys  Provide 'favorite' foods

Threaten  Change meal schedule  Send to room/time out

Ignore  Offer reward  Force feed

Punish  Praise  Provide 'mini-meals'

Change foods  Allow grazing/roaming  Chase around house with food

Other: __________________________________________________________________________

What does your child drink from (circle please):

Bottle  Sippy Cup  Open Cup  Straw

Is your child able to self-feed? Yes/No  spoon  fork

**Day Care/School**

Name of daycare/school: ___________________________  Director: _________________________

Address: ____________________________________  Phone: ___________________________

What meals are provided?  Please circle.

Breakfast  Snack  Lunch  Dinner

Do you provide food/beverages? Yes/No
If so, please describe:_______________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Is there something we did not ask, that you think would be helpful for us to know:
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

____________________________________________________________________________________________

______________________________            _____________________   __________________
Signature            Relationship to child   Date

We look forward to meeting you and your child!
**Food Intake Records**

**Instructions:**
Please record all food/fluid consumed by your child for 2-3 days. The days chosen should represent your child’s ‘usual’ intake. Do not record if your child is sick. The food intake records **must** be received 48 hours **BEFORE** your child’s scheduled evaluation. Please return completed forms by:

Faxing to: Inova Loudoun Rehabilitation Center: 703-858-6665  
**Attention:** Debbie Teune for feeding evaluations  
or Sheree Hughes for pediatric dietician evaluations  

Emailing to: debra.teune@inova.org  
Subject: feeding/nutrition  

Mail to: Inova Loudoun Rehabilitation Center  
Attn: Feeding/Nutrition  
44035 Riverside Pkwy., Suite 500A  
Leesburg, VA 20176

**Name:** ________________________________

*Meal type – Breakfast (B), Lunch (L), Dinner (D), Snack (S)*

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Meal Type</th>
<th>Food</th>
<th>Beverage</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Name: __________________________________________

*Meal type – Breakfast (B), Lunch (L), Dinner (D), Snack (S)*

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Meal Type</th>
<th>Food</th>
<th>Beverage</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For Your Child’s Feeding Evaluation….

Please bring:

Food & drink items that your child likes, as well as foods the she/he has difficulty with.

Your child’s utensils, such as bottle, cup, spoon &/or fork.

Your insurance card, photo ID and the prescription from your doctor ordering speech therapy for feeding difficulties.

A referral if required by your insurance.

Your child **HUNGRY!!**
Inova Loudoun Pediatric & Adult Rehabilitation Center

PEDiatric CASE HISTORY FORM

We ask that you please fill out this form as completely as possible. This information will assist us in understanding your child’s present developmental issue(s) and will aid us in planning appropriate testing and/or treatment procedures. ALL INFORMATION IS STRICTLY CONFIDENTIAL. PLEASE INFORM US IF AT ANY TIME THIS INFORMATION CHANGES.

**PLEASE NOTE: AFTER COMPLETION, PLEASE RETURN THIS FORM, ALONG WITH ANY OTHER PERTINENT ACADEMIC and/or MEDICAL REPORTS (e.g. IEP’s, previous therapy evaluations, Hospital discharge summaries, etc.) TO THE CENTER. AS SOON AS WE RECEIVE THIS INFORMATION WE WILL CONTACT YOU TO SCHEDULE AN APPOINTMENT. You can fax this completed form to 703-858-6665 or mail/drop off to the address above.

We thank you in advance for your time and effort in completing this form.

Form Completed by: ________________________ Relationship to child: ________________ Today’s Date _________________

I. FAMILY INFORMATION

Child’s Name______________________________ Nickname______________________________
Date of Birth__________ Age______ Sex____ Blog/Website______________________________
Address______________________________________________________________
City________________________ State_____________ Zip Code________________________
Reason for referral______________________________

Parent’s Marital Status: (circle one) never married / married / separated / divorced / widowed

Father’s Name__________________________ Mother’s Name________________________
Date of Birth__________________________ Date of Birth__________________________
Address (if different)____________________ Address (if different)____________________

Telephone:
Home______________________________ Telephone:
Home______________________________
Work______________________________ Work______________________________
Cell______________________________ Cell______________________________
Email______________________________ Email______________________________
Employer__________________________ Employer__________________________
Position__________________________ Position__________________________
Primary Language____________________ Primary Language____________________
Birth / Adoptive / Foster or Step Parent Birth / Adoptive / Foster or Step Parent
Please List names and ages of all other people living in the home:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
<th>Primary Language</th>
<th>Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

II. BIRTH HISTORY

Pregnancy: ___ normal or ___ complicated by ________________________________

Labor: ___ spontaneous ___ induced ___ premature ___ complicated by ________________________________

Delivery: ____ Cesarean ____ Vaginal ____ Breech ____ VBAC ____ Forceps ____ Vacuum

Apgar Score: (if known) __________

Single Birth: ______  Multiple Births: ______ twins ______ triplets ______ other

Gestational Age: ____ weeks  Birth Weight: ____ lbs. ___ Oz. / ________ grams

NICU: ____ No ____ Yes ________ days ________ weeks ________ months

Other complications: (e.g. breathing difficulties, tube feeding) ________________________________

III. RELEVANT MEDICAL HISTORY

Illnesses / Injuries / Surgeries / Hospitalization since birth:

___ High Fevers  ___ Head Injury  ___ Bone Fracture  ___ Frequent ear infections

___ Pneumonia  ___ PDA Repair  ___ Cleft Palate/Lip  ___ NG/G tube insertion

___ Encephalitis  ___ VP Shunt  ___ Other ________________________________

Current Medications: ________________________________________________

Supplements: _________________________________________________________

Allergies: __________________________________________________________

Immunizations: Regular Schedule / Altered Schedule / Other __________________

List any medical diagnoses with which your child has been labeled:

__________________________________________________

Pediatrician / Family Physician: ________________________________

Check and list any other healthcare professionals/surgeons involved in your child's care:

___ Neurologist  ___ Orthopedist  ___ Ophthalmologist/Optometrist

___ Osteopath  ___ Chiropractor  ___ Developmental Pediatrician

___ Dietician  ___ ENT  ___ Psychologist/Psychiatrist

___ Feldenkrais  ___ Massage  ___ Craniosacral Therapist

___ Audiologist: Last hearing screening and results: ________________________________

___ Other: __________________________________________________________

______
Previous Therapy Interventions (early intervention, school-based, etc.): __________________________

Date of most recent psychological / developmental evaluation: ____________________________

Dates of any medical tests such as MRI, CT scan, X-rays: __________________________

Other diagnostic tests and results: ______________________________________________

Other relevant FAMILY medical history: (i.e. learning disabilities, autism, genetic disorders, heart or breathing difficulties, allergies): ________________________________

IV. DEVELOPMENTAL HISTORY (Please note approximate age in months for each)

Rolled Over: ________________stomach to back ________________ back to stomach

Sitting: ________________stayed sitting when placed ________________ got self into sitting

Crawling: ______________________on belly ________________ on hands & knees

Standing: ________________________with support ________________pulled self to stand

Walking: ________________________with support ________________cruising around furniture

______________________ without support ________________walking independently more than 10 steps

Walking on toes: ______never ______ rarely ______ occasionally ______ frequently

Falls: ______never ______ rarely ______ occasionally ______ frequently

Baby Devices Used: (age & hours per day)

____________________Sling Swing ____________________ Exersaucer _______________ High Chair

____________________Jumper_________________________ Pac’n Play _______________ Bumbo or other sitter

Sensory Tolerance: (Check all that apply)

____ Allows feet to leave ground when swinging _____ Tolerates bare feet on variety of surfaces

____ Tolerates variety of body positions without fear (i.e. on back, off ground, etc.)

____ Tips head back during bathing/diaper changing w/o anxiety

Comments: ______________________________________________________________________________

Toileting: (Check all that apply)

____ urinates/defecates in toilet when placed there

____ Initiating use of toilet ______ Reliably uses toilet ______ Stopped wearing diapers

Communication: (Check all that apply)

____ Looks at caregiver ______ Smiles ______ Coos/babbles

____ Gestures bye-bye ______ Uses 5 words ______ Imitates sounds

____ Responds to name ______ Plays peek-a-boo ______ Puts two words together

____ Uses jargon (words that are not understandable but said in “sentences” where child’s inflection lets you know he is saying “something”) ______ Speaks in sentences

Feeding: (Check all that apply)

____ bottle ______ cup ______ straw ______ NG/G-tube (feeding schedule) __________________

____ solids ______ pureed ______ chunky/table food ______ has been exposed to nuts

Comments _______________________________________________________________________________
Fine Motor Skills: Fill out appropriate age category and check all that apply

- **Babies/Preschoolers:**
  - ____ Holds objects
  - ____ Brings hands to mouth
  - ____ Holds objects in both hands simultaneously
  - ____ Feeds self with fingers
  - ____ Bangs two objects together
  - ____ Feeds self with utensils
  - ____ Manipulating toys like pop beads or shape sorters
  - ____ Scribbling

Comments: ______________________________________________________________________________

- **Preschoolers/Elementary:**
  - Preferred hand: ____ right ____ left
  - ____ Dresses self independently
  - ____ Uses fasteners on clothing
  - ____ Grasps crayon/pencil (thumb and finger)
  - ____ Uses scissors

Comments: ______________________________________________________________________________

- **Elementary/Secondary:**
  - ____ Handwriting issues, explain ______________________________________________________________________________

V. SPEECH AND LANGUAGE INFORMATION

How does your child communicate with you? (pointing, grunting, gesturing, words, sentences, sign language, bring parent to item, etc) ______________________________________________________________________________

Has speech development ____ stopped? _____ reversed? If so, when, why, explain:

________________________________________________________________________________________

Please check any items listed below that are DIFFICULT for your child:

- ____ Eating a variety of foods
- ____ Recognizing common words
- ____ Understanding what he/she hears
- ____ Rhyming
- ____ Following directions or routines
- ____ Getting his/her point across
- ____ Answering questions
- ____ Thinking of words for things
- ____ Concepts of time (seasons, day/night, hours)
- ____ Pronouncing words correctly
- ____ Singing sounds/reciting nursery rhymes
- ____ Using a straw
- ____ Stating sounds of letters
- ____ Telling/retelling stories
- ____ Speaking in organizing/grammatically correct sentences
- ____ Blowing bubbles

VI. EDUCATIONAL INFORMATION

Name of school/daycare provider (in/out of home): ________________________________

List number of hours per week child is around children his/her same age: ________________________________

Describe your child’s interaction with peers: _____________________________________________________

________________________________________________________________________________________

List your school/daycare schedule:

<table>
<thead>
<tr>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
</tbody>
</table>

Present classroom teacher / special education teacher / therapist’s name: ________________________________

Additional Information: __________________________________________________________________________
Please check any areas of difficulty:

___Speech  ___Writing sentences/paragraphs  ___Organization  ___Handwriting  ___Fine motor
___Reading  ___Spelling  ___Math  ___Attention  ___Study habits  ___Mobility  ___Gym class

Please list your child’s academic strengths: _____________________________________________________

What kinds of grades/reports does your child receive? ____________________________________________

Describe your child’s attitude toward school: ____________________________________________________

Date of most recent educational evaluation, if applicable: __________________________________________

VI. BEHAVIORAL HISTORY

Please check all that describe your child:

___Friendly/easy going  ___Impulsive/impatient  ___Difficulty leaving parent
___Difficulty sleeping  ___Poor eye contact  ___Plays well with others
___Hyperactive  ___Overly sensitive to sounds  ___Cooperative
___Attentive  ___Has temper tantrums  ___Shows affection
___Sleeps well  ___Eats well  ___Daydreams often
___Shy  ___Plays make-believe  ___Mouth breather/snores
___Takes turns/shares objects  ___Doesn’t like to be touched  ___Poor memory
___Grinds teeth  ___Easily frustrated  ___Stubborn
___Still uses pacifier/sucks thumb  ___Clumsy/falls a lot  ___Cries easily
___Distractible/short attention span  ___Will not eat/touch certain textures
___Fearful when moved/startles easily  ___Cannot easily shift from one activity to another

VII. CHILD’S INTERESTS

Describe your child’s play activities / hobbies: ___________________________________________________

Approximate number of hours per week your child watches T.V. _____________________________________

Does your child attend community recreation classes, if so, please list: _______________________________
________________________________________________________________________________________

What incentives / rewards motivate your child? (stickers, food, privileges): _____________________________

What method of discipline do you practice at home with your child and is it effective? __________________
________________________________________________________________________________________

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my child’s identifiable health information ___/___/___ (current date) to
___/___/___ (maximum six months). I understand that this authorization is voluntary and may be revoked at any time. I
understand that if the organization authorized to receive the information is not a health plan or health care provider; the
released information may no longer be protected by federal privacy regulations.

Client Name: ____________________________________________ Date of Birth: ____________________________

Parent/Guardian Signature: __________________________________________________________________________
Inova Loudoun Pediatric & Adult Rehabilitation Center Service Policies

We would like to take this opportunity to welcome you to Inova Loudoun Pediatric and Adult Rehabilitation. Our Center’s mission is to provide excellent care to each patient in a timely manner. Our licensed and certified therapists and our front office staff are committed to providing you the highest quality services. In order for us to deliver care in the most efficient and effective way, we request your assistance in complying with our policies which we have established to guarantee you optimal care and progress.

1) Consistent attendance, crucial to progress during your course of treatment, is required.

2) All appointments are scheduled to allow for direct treatment, consultation and documentation. All appointments need to begin and end on time. Failure to be prompt for an appointment will reduce the amount of time available for treatment and interfere with treatment progress.

3) Failure to show up for your scheduled appointment and/or a cancellation with less than 24 hours notice will result in an automatic charge of $50.00 which must be paid prior to resuming services. Cancellation fees cannot be billed to insurance. Appointments are in HIGH demand and your early cancellation will give another person the opportunity to have access to timely care. Multiple cancellations (more than 1 in a 3 month period) and/or no-shows (more than 1) will result in “Same Day Scheduling” pending extenuating circumstances to be determined by your therapist(s). “Same Day Scheduling” refers to when an appointment is requested by the client and scheduled on the same day it is to take place. Availability of appointments can not be guaranteed.

4) We highly encourage any cancelled/missed appointments to be made up. Should you wish to make-up an appointment, please call the office for availability.

5) Front desk staff is responsible for cancellations and rescheduling of all appointments. All questions regarding services, insurance or billing should be directed initially to the front desk staff.

6) When a therapist is unable to keep a scheduled appointment with a client, the service may be provided by another qualified therapist upon the request of the client/responsible party as scheduling permits.

7) Payments are due at the time service is rendered. All clients are ultimately responsible for the cost of appointments scheduled and services received. Our Center will submit charges and accept reimbursement from insurance companies for which we are a provider. Please keep the front office staff informed of any insurance changes. Charges for claims denied will resort to the client for immediate payment. Please make sure you are aware and keep track of your insurance benefits.

8) Please give at least (2) weeks notice prior to discontinuing services to ensure that proper discharge planning/education can be provided by your therapist.

9) Observation(s) of you and or your child’s Evaluation and/or treatment session(s) may take place by another therapist, your therapist’s supervisor and/or by students in the field or interested in the field.

I have read, discussed, understand and accept the policies as presented here. Upon signing, I agree to comply fully with these policies.

___________________________________________________________           _______________
Client                              Date

___________________________________                       __________________________________     _______________
Parent/guardian if client under 18                            Clinician                 Date

(Rev.6/09; Eff 060308)
Emergency Information

Name: 

DOB: _______________ SSN: ____________________________

Emergency Contact Numbers:

1) Name: ___________________________ Relationship to Patient____________________
   Phone #:  (Home) ___________________________ (Cell) ______________________________

2) Name: ___________________________ Relationship to Patient____________________
   Phone #:  (Home) ___________________________ (Cell) ______________________________

Medical Diagnosis:

Medical History:

Allergies:

Current Medications/Dosage:

________________________________________

________________________________________

________________________________________

________________________________________

Primary Care Physician: ____________________________ Phone #: ___________________

Other Relevant Information:

Last Updated: __________
Next Update in 3 months: __________

06/09