Date: _____ Time: _____

Please complete entire application and provide a copy of your driver's license and insurance card.

Patient Name: _____ Date of Birth: _____

Address: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Parent/Legal Guardian: _____

Relation to Patient: _____ E-Mail: _____

In Case of Emergency: _____ Phone: ( ) _____

Primary Care Physician: _____ Phone: ( ) _____

Referring Physician: _____ Phone: ( ) _____

Insurance Information

Primary Insurance Provider:	Phone: ( )
Policy Holder:	Date of Birth:
Group Number:	ID Number:
Driver's License Number	

Primary Insurance Provider:	Phone: ( )
Policy Holder:	Date of Birth:
Group Number:	ID Number:
Driver's License Number	

Current Medical Providers

Name	Specialty	Phone

Medical History

Please attach any relevant testing results or therapy reports (i.e. X-rays, MRI, CT scan, etc.).

Diagnosis or Medical conditions (List all): _____

_____

_____

_____

APPLICATION FOR CONSTRAINT INDUCED MOVEMENT THERAPY

4820

PATIENT LABEL

Does your child have any of the following?

- ☐ Seizures
- ☐ Bone Density Loss
- ☐ Scoliosis
- ☐ Heart Problems/Hypertension/Heart Surgeries
- ☐ Breathing/Respiratory Problems
- ☐ Sensation Loss
- ☐ Other: _____
- ☐ Diabetes
- ☐ Vision/Hearing Difficulties
- ☐ Shunt (Hydrocephalus)
- ☐ G-Tube/Feeding Difficulties
- ☐ Kidney Problems
- ☐ Fatigue

Gross Motor Abilities: Check the following skills that your child is able to perform.

- ☐ Hold their head steady when in supported sitting
- ☐ Roll over independently
- ☐ Sit independently
- ☐ Assume sitting from lying down
- ☐ Crawl
- ☐ Pull to standing
- ☐ Stand with assistance
- ☐ Stand independently
- ☐ Cruise against furniture
- ☐ Walk holding on for support
- ☐ Walk independently
- ☐ Run/Jump/Hop/Skip

Hospitalizations, Surgeries and Medical Procedures

Please describe and include dates	Month	Year

Past or Current Therapy Services

Provider Name	Phone Number	Discipline(s)	Hours Seen Each Week/Month

List Other Past or Current Therapeutic Interventions
(Electrical stimulation, therapeutic taping, orthotics/splints, etc.)

Intervention	Date(s)	Frequency	Outcome

Equipment

List any adaptive equipment that your child is currently using; i.e. AFOs, splints, walkers, gait trainers, crutches, canes, wheelchair, stationary or mobile standers. _____

_____

CIMT SPECIFIC

Fine Motor Skills

Can your child do the following items?

- ☐ Reach for toys and grasp them
- ☐ Grasp toys in both hands
- ☐ Bring objects to midline or mouth
- ☐ Finger feed
- ☐ Use utensils to feed self
- ☐ Hold a writing utensil

Can your child complete the following movements without assistance using their affected arm?

- ☐ Bend wrist back without lifting forearm
- ☐ Open and close their hand
- ☐ Move the thumb away from the palm of the hand
- ☐ Raise arm at shoulder

Communication Skills

How does your child best communicate with you and others? _____

_____

Can your child make eye contact?	☐ Yes	☐ Sometimes	☐ No
Can your child follow 1-step commands?	☐ Yes	☐ Sometimes	☐ No
Can your child follow 2-step commands?	☐ Yes	☐ Sometimes	☐ No
Can your child follow complex commands?	☐ Yes	☐ Sometimes	☐ No
Is your child able to move his/her body parts upon request?	☐ Yes	☐ Sometimes	☐ No

What motivates your child? i.e. favorite toys, bubbles, music: _____

_____

Intensive CIMT Program Goals

What is the main goal you would like to address during your child's intensive program?

_____

_____

What fine motor goals would you like to address during your child's intensive program?

_____

_____

What goals would your child like to address during their intensive program?

_____

_____

Parent/Guardian Printed Name	Parent/Guardian Signature	Date	Time