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.).

Diagnoses or Medical conditions (List all): _____

_____

Date of Hip X-rays (Not older than 6 months): _____ Attached ☐ Yes ☐ No

Does your child have a history of any hip surgeries: ☐ Yes ☐ No Date: _____

APPLICATION FOR INTENSIVE THERAPY THERASUIT™ METHOD

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

Has your child received any of the following medical interventions?

- ☐ Botox/Dysport Injections (Date/Location): _____
- ☐ Serial Casting (Date/Site): _____
- ☐ Selective Dorsal Rhizotomy (Date): _____
- ☐ Muscle Lengthening(s) (Date/Site): _____

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

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. _____

Current Therapeutic Interventions

Name	Discipline	Frequency	Location	Phone

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 TheraSuit™ Method Program Goals

What is the main goal you would like to address during the Intensive Strengthening Program?

What gross motor goals would you like to address during the Intensive Strengthening Program?

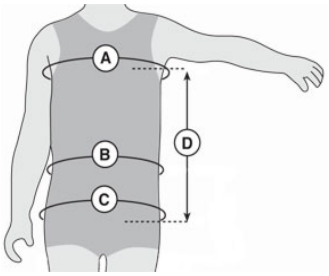
What fine motor goals would you like to address during the Intensive Strengthening Program?

Why is this an appropriate time for your child to have an Intensive Strengthening Program?

Intensive TheraSuit™ Method Program Specifications

Child's Height: _____ inches Weight: _____ lbs. Shoe Size: _____

Circumferences (measurements):



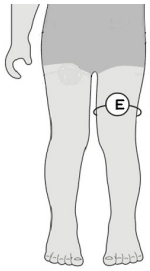
A. Chest: _____ inches

B. Waist: _____ inches

C. Hips: _____ inches

D. Length (underarm to hip): _____ inches

E. Thigh (mid): _____ inches



Parent/Guardian Printed Name	Parent/Guardian Signature	Date	Time