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

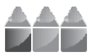
Please attach any relevant testing results or therapy reports (i.e. X-rays, MRI, CT scan, etc.).

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: ____________________



Wolfson Children's Hospital

Rehabilitation

Jacksonville, FL

Intensive Intake Form

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: ______________________________

____

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