Lone Star
Children's Therapy, Inc.

6002 Mercedes Avenue
Dallas, TX 75206

Phone 214.940.7876
Fax 214.824.3623
www.LoneStarChildrensTherapy.com

Welcome to Lone Star Children's Therapy, Inc.

The Following Items must be signed and mailed to Lone Star Children's Therapy, Inc. Prior to your first home or school appointment:

1. Privacy Practice Acknowledgment/Consent to Treat
1. Authorization to Disclose Protected Health information
2. Case History
3. A PRESCRIPTION from your primary care physician for OT Evaluation/Treatment
4. Any therapy or medical information that will assist us in treating your child.

Please Mail all information listed above to

Lone Star Children's Therapy, Inc.
6002 Mercedes Avenue
Dallas, TX 75206

Or Fax Information to 214.824.3623

Please call Marnie Danielson,
Owner of Lone Star Children's Therapy, Inc.,
If you have any questions.
Office 214.940.7876

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Please Fill Out & Return to Lone Star Children's Therapy, Inc.

Lone Star Children's Therapy, Inc. Authorization for the Release of Medical Records

I, as a personal representative of _____(name of minor patient), hereby authorize Lone Star Children's Therapy, Inc. to: Obtain all of this patient's medical records, case records, case histories, or personal and regular files, for the purpose of financial reimbursement, continuity of care and, case management from all former providers of medical services (to include: Primary care, Psychological, etc.)

Release all of this patient's medical records, case record, case histories, or personal and regular files, for the purposes of financial reimbursement, continuity of care, and case management. I understand and agree that a photocopy or facsimile of this executed authorization is as valid as the original.

Print name of Caregiver/ Guardian_____

Signature of Caregiver/ Guardian_____

Unless otherwise permitted by law, further release of this information is prohibited without my prior written consent. I fully understand this authorization, and it is made voluntarily on my part.

Consent to Treat

I, _____(parent), knowing that_____(child) has a diagnosis requiring Occupational Therapy treatment voluntarily consent to such care for the aforementioned child by Lone Star Children's Therapy, Inc. as may be beneficial in the professional judgment of the child's therapist and primary care physician. I am aware that no guarantee has been made to the effect of OT on my child.

Parent Initial_____

Acknowledgement of Receipt of Privacy Policy

Our Privacy Policy is available for download at www.lonestarchildrenstherapy.com/aboutus.html

I, _____ have read a copy of Lone Star Children's Therapy, Inc.'s Notice of Privacy Policy Practices with an effective date of 04-5-03.

Name of Patient _____

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Lone Star Children's Therapy, Inc. Case History Form

General Information

Child's Name: _____ Date: _____

Birth date: _____ Age: _____ Sex: _____ Male _____Female

Home Address: _____

_____

_____

Phone: _____

Home School: _____ Referred By: _____

Preschool or Day care: _____

Person filling out this form: _____Mother _____Father _____Stepmother _____Stepfather Other: _____

Mother's Name: _____ Day Phone: _____

Evening Phone: _____

Father's Name: _____ Day Phone: _____

Evening Phone: _____

Marital Status of Parents: _____

Email address: _____

Do you feel comfortable receiving emails regarding therapy services and your child _____ yes _____no

List of all people living in household:

Name	*Relation to Child*	*Age*	*Speech/Hearing or medical problem*

Primary Language spoken in the home: _____

WHAT ARE YOUR CONCERNS ABOUT YOUR CHILD?

(Include when this was first noticed, what may have caused it): _____

_____

_____

_____

_____

_____

_____

Has anyone else expressed concerns (i.e. family members, pediatrician, teachers, etc.)?

_____

_____

_____

Has your child been enrolled in speech therapy/other treatment programs or received testing? ___Yes ___No

If yes, please describe the program: _____

_____

_____

Medical History:

Primary Care Physician: _____

Developmental Physician: _____

Were there any problems during pregnancy or difficulties at birth? _____Yes _____No

Were there any health problems in the first 2 weeks of life? _____Yes _____No

Health:

Has your child has his/her hearing checked? _____Yes _____No Date:_____

Has your child has his/her vision checked? _____Yes _____No Date:_____

History of ear problems? _____Yes _____No

History of allergies, tonsillitis, or asthma? _____Yes _____No

Are there any diagnosed medical, physical, or emotional problems? _____Yes _____No

If yes please explain and give dates:_____

_____

_____

_____

Daily Behavior:

Does your child suffer from:

Socializing problems _____Yes _____No

Feeding problem _____Yes _____No

Sleeping problems _____Yes _____No

If you checked yes for any of the above, please explain:_____

_____

_____

_____

Is he/she toilet trained? _____Yes _____No

How does your child get along with other children? _____

_____

_____

Age of playmates? _____

Developmental Milestones:

Behavior	*Age*
Crawled	_____
Walked alone	_____
Spoke first word	_____
Put several words together	_____
Dressed self	_____
Became toilet trained	_____
Communication:	_____

How does your child usually let you know he/she wants?_____

_____

_____

How does your child communicate? _____

_____

_____

Does your child:

Answer when you talk to him/her? _____Yes _____No

Talk about what he/she/ is doing? _____Yes _____No

Ask for help? _____Yes _____No

What does your child like to talk about?_____

_____

_____