



Lone Star Children's
Therapy, Inc.
(214) 490-7876

LoneStarChildrensTherapy.com

Welcome to Lone Star Children's Therapy, Inc.

**The following items must be signed and emailed to
Lone Star Children's Therapy, Inc.,
Prior to your first home or school appointment.
Marnie@lonestarchildrenstherapy.com**

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.

Questions

**Call Marnie Danielson, Owner
of Lone Star Children's Therapy Inc,
(214) 490-7876**



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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
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_____	_____	_____	_____
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_____	_____	_____	_____
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_____	_____	_____	_____
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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? _____
