



BETH INGRAM THERAPY SERVICES
Speech-Language Therapy • Occupational Therapy • Physical Therapy

PROFESSIONAL PHILOSOPHY

It is our desire to provide the highest quality of medical care to our patients and to do this in a professional and empathetic way. It is our intention to accomplish these goals through personalized care presented in a comfortable manner.

ATTENDANCE POLICY

Consistent attendance is essential for your child’s progress in therapy. The time for your child’s appointment has been exclusively reserved for you and your child. Regularly scheduled appointments occur on the same day and time each week. Frequent cancellations and/or two consecutive “no shows” may result in a loss of your appointment time or discharge from therapy. **PATIENTS MAY BE REMOVED FROM THE SCHEDULE IF UNABLE TO MAINTAIN 80% ATTENDANCE AND IS SUBJECT TO A WEEK-TO-WEEK APPOINTMENT STATUS AFTER TWO CONSECUTIVE MISSED APPOINTMENTS.** Therapy must be consistent in order to be beneficial. Parents are encouraged to observe therapy sessions in order to facilitate the carry-over of learned therapeutic techniques. **The parent/guardian must remain on site for the duration of a child’s session in case of an emergency, toileting issues, etc.**

I DO/DO NOT (circle one) authorize Beth Ingram Therapy Services to send email* and /or voicemail message appointment reminders to confirm appointments, to send email evaluation reports or to send email billing statements.

** Beth Ingram Therapy Services (BITS) will use reasonable means to protect the privacy of your health information sent by e-mail. BITS will not be liable in the event you or anyone else inappropriately uses your e-mail. BITS will not be liable for improper disclosure of your health information not caused by BITS' intentional misconduct.*

I DO/DO NOT (circle one) authorize Beth Ingram Therapy Services to send text message appointment reminders to me on my provided cell phone number. I understand text message charges from my cell phone provider may apply.

FINANCIAL RESPONSIBILITY POLICY

By signing below, you acknowledge that you have read, understand and agree to abide by the Patient Financial Policy terms. It is your responsibility to provide us with your correct and current insurance information at the time of your visit. You must inform us of any change in your insurance information once you receive notice of any coverage changes from your insurance carrier.

NOTICE OF PRIVACY PRACTICES

As a part of your child’s care, Beth Ingram Therapy Services will originate and maintain paper and/or electronic records describing your child’s health history, symptoms, evaluation and test results, diagnosis, treatment, and any plans for future care or treatment. The Notice of Privacy Practices that provides a description of Protected Health Information uses and disclosures has been provided to you. Beth Ingram Therapy Services reserves the right to change its Notice of Privacy Practices that will be effective for health information the clinic already has about you, as well as any received in the future. We will post a current copy of the Notice for your review. You may also obtain a copy of the current Notice in effect upon request.

PERMISSION FOR MEDICAL TREATMENT

Permission is hereby granted for therapists, employees or agents of Beth Ingram Therapy Services to render the patient named below medical treatment as deemed necessary. Such care may include, but not be limited to diagnostic evaluations and procedures considered advisable in the diagnosis, treatment and course of care. I understand that he/she will be expected to follow treatment plans that are mutually agreed upon between the treating clinician, primary care physician, and me.

I certify that I am the parent or legal guardian and that I can exercise all rights for said child. My signature below acknowledges that I have read all of the above and understand/agree to all provisions therein regarding attendance, responsibility for payment, permission for treatment and Notice of Privacy Practices.

PATIENT’S NAME: _____
(Please Print)

Date of Birth

SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE

If Legal Guardian, relationship to patient: _____



BETH INGRAM THERAPY SERVICES FINANCIAL POLICY

Patient Name: _____

Date: ____/____/____

Thank you for choosing Beth Ingram Therapy Services to provide you with your therapy needs. We are pleased to participate in your care and look forward to providing you with world class therapy services. As part of this relationship, we wish to establish expectations of your financial responsibility as outlined in our Financial Policy. *Your medical insurance is a contract between you and your insurance company. We can help with providing information related to outpatient therapy services but you are primarily responsible for all charges that are incurred as a patient with Beth Ingram Therapy Services.* Please review this information and sign prior to your initial visit with our office.

Payment Responsibility I understand as a recipient of medical care I am responsible for all charges regardless of my circumstances for reimbursement. I understand it is my responsibility to be aware of the requirements and limitations of my own insurance plan benefits. I understand there is a fee charged for all visits, examinations, treatments, and medical reports. Co-pays and/or co-insurance are due at the time of service. I agree to provide Beth Ingram Therapy Services with complete and accurate information, including but not limited to; picture identification, current insurance card, a referral or authorization for visits or procedures if required. We are required to update this information on an annual basis, at minimum. I agree to pay for any service, supply, or visit that my therapist deems necessary if not paid by my insurance. **During the course of treatment if my or my child's insurance or benefits become inactive or discontinued for any reason, I agree to continue services for myself or my child at the agreed upon self pay rate. We may require information or assistance from you in order to get your claims processed and paid. It is your responsibility to comply with our request in a timely manner. Please be aware that the balance of your claim is your responsibility whether your insurance provider issues payment or not.**

Insurance Verification: As a courtesy to our patients, we complete an investigation of benefits for therapy services. It is the patient's responsibility to verify coverage, understand their particular insurance benefits and ensure that payment is made. In the information attached we are **ESTIMATING** the amount you will need to pay for therapy services. Insurance verification is not a guarantee of payment and we encourage you to contact your insurance company to better understand your benefit for therapy services. If payment is for any reason denied you will be responsible for the amount your insurance company deems is patient responsibility. **Please contact the business office immediately if there are any changes to your insurance or if your insurance terminates.**

Non-Covered Services: Insurance does not pay for all of your healthcare costs; some items and services are considered "non-covered benefits" under your health insurance plan and as such, your insurance will not pay for these services. Should you choose to receive these services; you will be personally responsible for the payment of such services. Once a determination has been made that the therapy services recommended are "non-covered benefits" under your plan, you may be eligible to participate in our Self-Pay plan and receive a discount on services.

Self-Pay In order to make our services accessible for people not covered by insurance, those who have an insurance policy with no out of network benefits, those whose insurance does not cover therapy services, or those whose insurance benefits have been exhausted for the year, we offer a self-pay plan. Charges are reduced by 20% for evaluations and an average of 40% per therapy visit (varies based on type of therapy required). Payment in full is due at the time of service unless an election is made to participate in one of the company's automated payment programs for recurring bank or credit card transactions. If a self-pay patient fails to make more than two (2) consecutive scheduled payments then the Self-Pay Plan will be forfeited and the patient will be obligated to pay the full standard rate for services rendered.

Missed Appointment Policy I understand the outcome of treatment depends highly on keeping scheduled appointments that are reserved. Beth Ingram Therapy Services reserves the right to charge \$25.00 for missed appointments or cancellations without a 24-hour advance notice. If three scheduled appointments are missed my chart may be administratively closed and future sessions discontinued. Should this become necessary I will receive written notification as well as my referring physician, and insurance company (if required).

Returned Checks There is a \$25.00 charge for any returned check in addition to the original amount of the check. This must be paid by cash, certified funds, or credit card prior to any additional visits.



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Delinquent Accounts If your account becomes over 90 days past due with nonpayment, we will take the necessary steps to collect this debt. You will receive a letter stating you have 10 business days to pay your account in full. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency. If we have to refer your account to collections you agree to reimburse us the fees of any collection agency, which will be added to your account when it is placed with a collection agency, and may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Method of Contact I agree that in order for Beth Ingram Therapy Services to service my account or to collect any amounts I may owe, Beth Ingram and their agents and affiliates may contact me by telephone at any telephone number associated with my account or any of my telephone numbers they may discover, including wireless telephone numbers, and that such contacts could result in charges to me. I agree that methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable, e-mails, text messages, and facsimiles.

Statement of Confidentiality I authorize the release of necessary medical information to Beth Ingram Therapy Services for the purpose of processing this or any related insurance claims. I also give Beth Ingram Therapy Services the authority to make available any requested documents contained in my file to myself and/or other health care providers involved in the treatment of my condition.

Assignment of Benefits I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Beth Ingram Therapy Services for any services provided to me.

Medicare I understand that as a Medicare beneficiary, I have a maximum benefit for outpatient physical therapy services. Beth Ingram Therapy Services will monitor your visits and make you aware as you near the maximum allowed by Medicare. I am responsible to make Beth Ingram aware of any previous treatment I may have had at another facility in the past 12 months. Medicare will not pay for outpatient therapy services while you are receiving home services. It is my responsibility to make sure my home health agency has discharged me for their care. I understand that I am responsible for full payment on any services provided over the maximum allowed amount.

Acknowledgement I understand that as part of my care, Beth Ingram Therapy Services will originate and maintain paper and/or electronic records describing my health history, symptoms, evaluation and test results, diagnosis, treatment, and any plans for future care or treatment.

By signing this document, I also acknowledge that I have received and understand a copy of the organization's Notice of Privacy Practices. This acknowledgment is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights and privileges.

***I have read the financial policy and agree to its terms. All questions have been answered prior to my signing this policy.**

Signature of Parent/Legal Guardian (Guarantor)

_____/_____
Date

Print Name

Social Security Number

Relationship to Patient



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AUTHORIZATION FOR OTHER INDIVIDUAL TO ACCOMPANY MINOR CHILD

PLEASE COMPLETE THIS FORM IF ANYONE OTHER THAN THE PARENT/LEGAL GUARDIAN WILL BRING THE CHILD TO THE EVALUATION OR THERAPY APPOINTMENT(S)

A parent or legal guardian must accompany a child younger than 18 years of age to consent for all medical treatment provided by Beth Ingram Therapy Services. It may be more convenient to have prior authorization so that medical care may be delivered directly to minors if a parent or legal guardian is not present prior to or during treatment. Please review the following authorization for treatment and complete the information if you want to authorize another individual to accompany your child for treatment.

AUTHORIZATION FOR OTHER INDIVIDUAL TO ACCOMPANY MINOR

I have the legal right to preauthorize this facility to deliver medical treatment to:

PATIENT'S NAME

____/____/_____
DATE OF BIRTH

I, undersigned, as the parent or legal guardian hereby authorize Beth Ingram Therapy Services to provide diagnostic and/or therapy treatment of my minor child. I understand that I am financially responsible for all non-covered medical expenses incurred by my child during these appointments. The following individual(s) may also receive diagnostic results and additional information pertinent to the care and treatment of my child:

I authorize _____
Name of person(s) being authorized

Relationship to Patient

Name of person(s) being authorized

Relationship to Patient

Name of person(s) being authorized

Relationship to Patient

This authorization is valid from ____/____/____ to ____/____/____.

This consent will be valid for one year from the date of signature unless stated differently.

I understand I may revoke this consent any time in writing.

PARENT/LEGAL GUARDIAN SIGNATURE

____/____/_____
DATE

PRINT NAME

(____) _____
CELL PHONE NUMBER



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AUTHORIZATION FOR RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Please complete this form if you consent to the release of your records or your child's medical records to the named individual/entity listed below.

PATIENT NAME: _____ DOB: _____

This form is used to release or disclose Protected Health Information (PHI) as required by state and federal laws. Your authorization allows the release of your PHI to the individual or organization that you choose.

I authorize Beth Ingram Therapy Services to release/or obtain Protected Health Information to/from the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Complete Records: Any and all personal and protected health information.

Or Check all that apply

- Evaluation Reports Treatment notes Progress Summary Discharge Summary
- Billing Records Plan of Treatment Attendance in treatment (Admission and discharge dates)
- Other: _____

The purpose of this release of information:

- Provide continuity of patient care Coordinate treatment Personal use Educational
- Attorney/Legal Other: _____

NOTE: This consent form allows personal and protected health information to be shared via telephone call with the individual or organization being authorized.

RIGHT TO REVOKE: Your authorization is voluntary and may be revoked at any time by submitting a request in writing except to the extent that action has already been taken in response to this authorization.

EXPIRATION: This authorization will expire on _____. *If no date is specified, this authorization will expire twelve (12) months from the date it was signed.*

CONSENT: I authorize the use or disclosure of personal and protected health information described above to the individual(s) or organization(s) identified above. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

Signature of Patient/Parent/Legal Guardian

____/____/____
Date

Legal Guardian Relationship to Patient: _____



MISSED APPOINTMENT/ATTENDANCE POLICY AGREEMENT

We are pleased that you have chosen to bring your child to Beth Ingram for therapy services. In order to provide the best possible treatment for the many children we see, we would like you to understand our missed appointment and attendance policies.

Our policy requires:

- **REGULAR ATTENDANCE:** Sessions are scheduled for each patient on the same day and time each week. At least 80% of Speech-Language Therapy and 90% of Occupational Therapy/Physical Therapy scheduled appointments must be attended to secure your permanent appointment time. If attendance falls below the required levels or the patient is chronically tardy, it may be necessary to decrease or discontinue services.

Initials

- **TIMELY CANCELLATIONS:** If you need to cancel or reschedule an appointment, you must give us at least a 24 hour notice. Cancellations made with less than a 24 hour will be considered a No Show.

Initials

- **ON TIME ARRIVALS:** If you are more than 10 minutes late, you may be asked to reschedule the appointment. This will be considered a No Show appointment.

Initials

- **MULTIPLE APPOINTMENT CANCELLATIONS:** If you have two children scheduled for an appointment on the same date or appointments scheduled for more than one discipline (i.e. Speech Therapy at 2:30pm and Occupational Therapy at 3:00pm) on the same date, and both appointments are No Shows, you will no longer be allowed to schedule more than one child or more than one discipline on the same appointment date.

Initials

- **COMPLIANCE:** Patients are only allowed ONE No Show appointment and TWO cancellations in a 6 month authorization period. After the second No Show or third cancellation the patient will be removed from the permanent schedule and placed on a week-to-week status.

Initials

The most important thing you can do to make sure your child gets the most from his or her therapy is to attend sessions regularly and arrive on time. We value you as our patient and need your cooperation in keeping appointments.

Patient or Parent/Guardian Signature

Date



CURRENT CONCERNS							
Reason for today's visit:	<input type="checkbox"/> Speech <input type="checkbox"/> Language <input type="checkbox"/> Gross Motor <input type="checkbox"/> Fine Motor <input type="checkbox"/> Mobility <input type="checkbox"/> Feeding <input type="checkbox"/> Sensory Processing						
Select any evaluations within the last six months?	<input type="checkbox"/> None <input type="checkbox"/> Speech/Language <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy When? _____ Where? _____						
Describe your concerns:							
When was the problem first noticed?							
Describe any problems that appear to be a result of your child's difficulty:							
How do you and your family members react to this problem?							
What are your goals for treatment?							
Check any special equipment used by your child:	<input type="checkbox"/> Wheelchair <input type="checkbox"/> Braces <input type="checkbox"/> Walker <input type="checkbox"/> Eye Glasses <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Communication Device <input type="checkbox"/> Other _____						
Does your child have any pain?	<input type="checkbox"/> NO <input type="checkbox"/> YES If yes, where: _____						
Describe the pain:	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Ache <input type="checkbox"/> Pins and needles						
Frequency of Pain:	<input type="checkbox"/> Constant <input type="checkbox"/> Comes and goes <input type="checkbox"/> Morning <input type="checkbox"/> Night <input type="checkbox"/> With Activity						
Sensory Aversion/Triggers:	_____ <input type="checkbox"/> None						
FAMILY BACKGROUND							
What is the primary language spoken in the home?	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> Arabic <input type="checkbox"/> Other _____						
What is the child's dominant language?	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> Arabic <input type="checkbox"/> Other _____						
Other children in the family:	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; border-bottom: 1px solid black;">Name</td> <td style="width: 40%; border-bottom: 1px solid black;">Age</td> </tr> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> </table>	Name	Age				
Name	Age						
Are there any family members or relatives who have or have had the same problem?	<input type="checkbox"/> NO <input type="checkbox"/> YES If yes, who and what kind?						



BIRTH HISTORY			
Were there any illnesses or complications during pregnancy with this child?	<input type="checkbox"/> NO <input type="checkbox"/> YES If yes, explain?		
Pregnancy term and birth weight:	Full Term: <input type="checkbox"/> YES <input type="checkbox"/> NO If no, how many weeks?	Birth Weight: _____	
Delivery Method:	Via: <input type="checkbox"/> C- Section <input type="checkbox"/> Vaginal <input type="checkbox"/> Breech		
Were there any drugs or medications taken during this pregnancy?	<input type="checkbox"/> NO <input type="checkbox"/> YES If yes, explain?		
Were there any immediate problems following the birth or during the first 2 weeks of the infants life?	<input type="checkbox"/> NO <input type="checkbox"/> Jaundice <input type="checkbox"/> Surgery <input type="checkbox"/> Feeding <input type="checkbox"/> Required Oxygen <input type="checkbox"/> Sucking or swallowing problems <input type="checkbox"/> Sleep patterns		
MEDICAL HISTORY			
How is your child's overall health?	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
Are immunizations up to date?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Does your child have any known allergies?	<input type="checkbox"/> None <input type="checkbox"/> Yes If yes, please list: _____		
List all medications and dosages currently prescribed for the patient	MEDICATION	DOSAGE	PURPOSE
Does your child have a history of surgery/hospitalization?	<input type="checkbox"/> NO <input type="checkbox"/> YES If yes, please explain?		
How would you characterize your child's diet?	<input type="checkbox"/> Regular All foods allowed: no known food allergies or dietary restrictions <input type="checkbox"/> Regular With exceptions: List food allergies/dietary restrictions: _____ <input type="checkbox"/> Pureed (requiring very little chewing ability) <input type="checkbox"/> Mechanical Altered (requiring some chewing) <input type="checkbox"/> Advanced (soft foods that require more chewing ability)		
Please check the following as they apply to your child:	<input type="checkbox"/> Autism/PDD/Asperger <input type="checkbox"/> ADHD/ADD <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Dyslexia <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Learning Disability <input type="checkbox"/> Birth Defects <input type="checkbox"/> Psychological /behavioral issues <input type="checkbox"/> None		
Has your child had any of the following conditions?	<input type="checkbox"/> Asthma <input type="checkbox"/> Low birth weight <input type="checkbox"/> Cleft Lip <input type="checkbox"/> Cleft Palate <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Food Sensitivities <input type="checkbox"/> Spinal cord injury	<input type="checkbox"/> Sprains <input type="checkbox"/> Strains <input type="checkbox"/> Spasms/Cramps <input type="checkbox"/> Fractures/broken bones <input type="checkbox"/> Degenerating Joints <input type="checkbox"/> Head Injury <input type="checkbox"/> Nerve injury	<input type="checkbox"/> Gastric Reflux <input type="checkbox"/> Diabetes <input type="checkbox"/> Adenoidectomy <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Visual Impairments <input type="checkbox"/> Juvenile Arthritis
Please describe any other relevant medical diagnosis:			



EDUCATIONAL BACKGROUND						
Age at entrance to school: _____ years _____ months	<input type="checkbox"/> N/A <input type="checkbox"/> Preschool <input type="checkbox"/> Home Daycare <input type="checkbox"/> Kindergarten Current school: _____ Grade: _____ Grades Repeated: _____					
Type of classroom	<input type="checkbox"/> Regular <input type="checkbox"/> Exceptional Student Special Program _____					
Does your child have an IEP?	<input type="checkbox"/> NO <input type="checkbox"/> YES Program: _____					
Indicate any/all areas of difficulty:	<input type="checkbox"/> Reading <input type="checkbox"/> Math <input type="checkbox"/> Spelling <input type="checkbox"/> Handwriting <input type="checkbox"/> Writing sentences <input type="checkbox"/> Interacting with others					
BEHAVIORAL BACKGROUND						
Please check as they apply to your child:		YES	NO		YES	NO
	Friendly/Outgoing			Mostly quiet		
	Is usually happy			Poor Memory		
	Is frustrated easily			Impulsive/Restless		
	Poor turn taking skills			Difficulty concentrating		
	Poor eye contact			Lacks pretend play		
	Sleeping Difficulties			Avoids group play		
	Attentive			Recognizes danger		
	Cooperative			Avoids eye contact		
	Eating Difficulties			Withdrawn		
	Destructive/Aggressive			Overly active		
	Thumb/finger sucking habit					
	Exhibits difficulty learning new tasks					
	Imitates actions / speech					
	Difficulty with transitions/Resistant to change					
	Difficulty separating from parent					
	Self- stimulation/ self-injury					
Plays with toys appropriately						
Understands praise/punishment						
Plays alone for reasonable amount of time						
HEARING						
Has the patient's hearing ever been tested?	<input type="checkbox"/> NO <input type="checkbox"/> YES If yes, Where? When? By whom? What were the results/recommendations? _____					
How many ear infections has your child had?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 10 or more					
Has your child worn Pressure Equalization Tubes (PE Tubes)?	<input type="checkbox"/> NO <input type="checkbox"/> YES Which ear(s): _____ How Long? _____					
Does your child have a diagnosed hearing impairment?	<input type="checkbox"/> NO <input type="checkbox"/> YES If yes, Where? When? By Whom? Is the loss in one or both ears? What is the level of loss? _____					
Does your child wear hearing aids?	<input type="checkbox"/> NO <input type="checkbox"/> YES If yes, which ear(s) are the aids worn? _____					



GROSS AND FINE MOTOR SKILLS				
Does your child lose their balance or fall easily?	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Indicate with a check mark any/all areas of difficulty:	<input type="checkbox"/> Zippers/Buttons <input type="checkbox"/> Hopping/jumping <input type="checkbox"/> Dressing <input type="checkbox"/> Handwriting <input type="checkbox"/> Lacing/tying shoes <input type="checkbox"/> Walking backwards <input type="checkbox"/> Torticollis <input type="checkbox"/> Accepting weight into legs <input type="checkbox"/> Pulling to sit/stand <input type="checkbox"/> Walking up/down steps <input type="checkbox"/> Building tower with blocks <input type="checkbox"/> Balancing	<input type="checkbox"/> Rolling over back to stomach <input type="checkbox"/> Rolling over stomach to back <input type="checkbox"/> Standing at furniture <input type="checkbox"/> Throwing ball overhand <input type="checkbox"/> Sitting Alone <input type="checkbox"/> Standing Alone <input type="checkbox"/> Walking/Running/Jumping <input type="checkbox"/> Creeping on hands and knees <input type="checkbox"/> Bearing weight on arms <input type="checkbox"/> Bringing hands together at midline <input type="checkbox"/> Transferring objects from hand to hand <input type="checkbox"/> Lifting head while on stomach		
Did your child: Hold his/her head up by 4 months Sit alone by 6 months First walk alone by 16 months Potty-trained by 3 years Feed self by 2 years Use scissors by 3 years Grasp crayon/pencil by 3 yrs	<input type="checkbox"/> YES <input type="checkbox"/> NO If no, age in months _____ <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO If no, age in months _____ <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO If no, age in months _____ <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO If no, age in months _____ <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO If no, age in months _____ <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO If no, age in months _____ <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO If no, age in months _____ <input type="checkbox"/> N/A			
SENSORY MOTOR SKILLS				
Please answer the following statements:		Always	Sometimes	Never
Does your child seem overly awkward, uncoordinated or clumsy (poor body awareness)?				
Is your child overly sensitive to or extremely bothered by lights /sounds?				
Often sits in a "W sit" position on the floor to stabilize body.				
Has difficulty telling the difference between similar printed letters or figures; i.e., p /q, b /d, + / x, or square/rectangle				
Does your child avoid eating certain food textures/temperatures?				
Irritable when being dressed; uncomfortable in clothes.				
Is not bothered by injuries. Does not notice pain or is slow to respond when hurt.				
Is not aware of being touched/bumped unless done with extreme force or intensity.				
Has a hard time seeing the "big picture"; i.e., focuses on the details, background noises.				
Rocks body, shakes head/arms while sitting.				