Behavioral Information

Does your child currently have any behavioral health conditions or autism related services? If so, please describe

_____

Does your child self harm or harm others?_____

Is there any family history of behavioral health treatments?_____

What are your child's favorite foods, toys, games, and activities?

_____

What else would you like us to know about you and your child's cultural variables that may affect treatment?

_____

_____

_____

_____

Medical History

I CURRENTLY have or have had a HISTORY of: (please circle all that apply)

Y	N	Tinnitus	Y	N	Tonsillitis	Y	N	Allergies
Y	N	Swallowing Difficulty	Y	N	Seizures	Y	N	Mumps
Y	N	Tonsillectomy	Y	N	Colds	Y	N	Colds
Y	N	Sinusitis	Y	N	Headaches	Y	N	Vision Problems
Y	N	Otosclerosis	Y	N	Dizziness	Y	N	Hearing Problems
Y	N	Pneumonia	Y	N	Asthma/Short of Breath	Y	N	Measles
Y	N	Severe Night Pain	Y	N	Kidney Problems	Y	N	Meningitis
Y	N	Voice Problems	Y	N	Loud Noise Exposure	Y	N	Bruising Easily
Y	N	Hearing Loss	Y	N	Adenoidectomy	Y	N	Nervous Disorder
Y	N	High Fever	Y	N	Draining Ear	Y	N	Ear Infections

PATIENT AUTHORIZATION **(PARENT CONSENT IS NEEDED IF PATIENT IS UNDER THE AGE OF 18)**

I hereby authorize my consent as a Parent / Guardian of : _____ **for speech therapy evaluation and treatments rendered by Glinn & Giordano Physical Therapy, Inc.** (signature) _____.

The undersigned authorizes Glinn & Giordano Physical Therapy, Inc. to release medical information as requested by insurance companies, employers and other responsible parties, unless otherwise directed. In the event authorization to release information is denied, payment for all services must be made at the time of service. I understand that any co-payment or share of cost will be charged and I am responsible for payment of all co-payments, share of costs or deductibles.

I also authorize payment of medical benefits from my insurance company or third party payer to Glinn & Giordano Physical Therapy, Inc.

I give Glinn & Giordano Physical Therapy, Inc. my consent to perform physical therapy services according to the recommended plan of treatment provided by my therapist.

Responsible Party (signature): _____

Responsible Party (address): _____

Patient Name (please print): _____

Patient Signature: _____ Date: _____