Phone: 870-919-0274
Fax: 870-277-4335

CONFIDENTIAL INFORMATION TO EVALUATE

Child's name____________________________________ Parent/Guardian name___________________________________

Date of birth_____________________________________ Primary Care Physician___________________________________

Medicaid/ARKids number_________________________ Social security number___________________________________

Physical address__________________________________ Mailing address____

City____ State_______ Zipcode____________________

Cell phone_________________________ Home phone_________________________ Work phone_______________________________

Was your child born full term? Yes/No If No, how many weeks gestation?_________________________________

Birth weight: _____pounds______ounces Vision loss? Yes/No Hearing loss? Yes/No

Complications with pregnancy? Yes/No If yes, please explain
____

____

Complications with delivery? Yes/No If yes, please explain____

____

Major illnesses/surgeries? Yes/No If yes, please describe____

____

Medications:____

Allergies: Yes/No If yes, please list:____

Age started:

sitting independently_____________crawling___________walking_______________talking________________

feeding self_______________ button's shirt_________________ put shoes on/off_____________________

Child lives with: (circle all that apply) Father Mother Guardian Other

Has your child ever been tested or received Occupational, Physical, or Speech Therapy in the past? Yes/No

If yes: When____
Where____

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Parent/Guardian/Caregiver concerns with child's development/milestones____

____

All other insurances not Medicaid/ARKids:

Insured First, Middle, Last Name____ Date of birth__________________

Social Security number________________________________ Place of employment_______________________________________

(Will also need a copy of the front and back of insurance card before evaluations can be performed if not Medicaid/ARKids)

I give Jumping Jelly Beans Pediatric Therapy PLLC, permission to perform any occupational, physical, speech therapy evaluation as well as therapy if deemed necessary; release evaluations and therapy documentation to primary care physician, insurance company, day time facility, and public schools as needed; bill any insurance company including Medicaid or ARKids.

Parent/Guardian Signature:____ Date__________________

Relation to child: ____________________________________ Printed name:____________________________________