Deirdre McDowell, PLLC • Houston, 811 Arlington Street • Houston, Texas 77007

[1]Deirdre McDowell, PT, PCS
Pediatric Physical Therapy
Evaluation, Intervention and Consultation

TO SCHEDULE AN APPOINTMENT WITH DEIRDRE MCDOWELL

· Complete the Client Information Form (CIF, attached). All information requested is important. However, don't wait to get things like Apgar scores or head size. Forms without clearly stated concerns on page 3 will be returned to you for clarification. Sometimes it is easier to use a computer and attach the page(s) rather than use the lines on that page. If you have a discharge summary or medical records from delivery or a recent hospitalization please include them.

· Returning clients must also send the CIF in order to be scheduled. The *top* of page 2 requesting history of pregnancy and development can be omitted since that will not have changed. But the remainder of the form must be completed, even if the information has not changed since the last appointment.

· Make your $50 check payable to "Deirdre McDowell, PLLC."

· **MAIL** the PIF, any recent testing, and your check for $50 to:

Deirdre McDowell, PLLC
811 Arlington Street
Houston, Texas 77007

· You may drop the forms off at my office on Mondays between 8 a.m. and 10 a.m. or a specifically scheduled time by calling in advance. I will not be able to schedule the appointment at that time since the information must be reviewed first.

· I will call you within 48 hours after receiving forms.

I DO NOT ACCEPT FAXED FORMS. NO EXCEPTIONS.

· You can assume your child's appointments will be initially scheduled at least 1 to 2 weeks from this date. However, I keep a **WAITING LIST** of people *who have returned all forms* and wish to be called if an earlier appointment becomes available. (And this does happen!)

· Remember I **do not file** with your insurance company. I will collect **payment in full** at the time of each scheduled appointment by cash, VISA, MasterCard, or American Express. You will be provided with a statement to file with your insurance at either the second appointment or in the mail with your report.

· Still have questions? Contact me. deirdremcdowell@me.com

Deirdre McDowell, PT, PCS
Physical Therapy Pediatric Clinical Specialist

Deirdre McDowell, PLLC
811 Arlington Street • Houston, Texas 77007
Telephone (713) 299-3079 FAX (713) 863-1722

For Office Use Only
Date Returned:

CLIENT INFORMATION FORM

CHILD'S LEGAL NAME .....
(first) (middle) (last)

Gender ..... Birthdate .....

BY WHAT NAME IS THE CHILD CALLED? .....

WITH WHO DOES THIS CHILD LIVE?

Name(s) .....

Relationship(s) to Child

Give the following information for the child's **parents**:

Full Name of Parent ....
Circle one: mom / dad Birthdate Age

Address (street address) (city, state) (ZIP)

Education Completed Through: ..... Home Phone .....

Occupation ..... Cell Phone .....

Employer .....

Brothers and Sisters (list ALL at home or away)

Name	Gender	Age	Occupation or School	Grade
.....				
.....				
.....				
.....				

PREGNANCY

Mother's age at delivery……..

Mother's total number of pregnancies …….. Patient was pregnancy number…….. Number of living children……

During this pregnancy: Weight gain ……lbs. medications ……

Was bed rest required? Why? …… For how long?

BIRTH HISTORY (please circle or note as indicated for **ALL** items)

Labor:	spontaneous	Induced	Other
Delivery:	Vaginal	Forceps	Vacuum
	c-section, scheduled	c-section, emergency	
	If emergent delivery, why?		

Place of delivery:

Gestational age:	Due date:	Birth weight:	Height:	Head size:
APGAR scores:	Did (s)he breathe promptly?	Was oxygen required?	Was a ventilator required?	
Was (s)he admitted to NICU after delivery?	If so, for how long?	Was (s)he jaundiced?	After how many days in the hospital was (s)he discharged?	

DEVELOPMENT (At what age did each of the following occur?)

……Pushed up onto arms when on tummy

……Rolled from back to tummy	……Rolled from tummy to back
……Got up onto hands and knees	……Got into sitting by themselves
……Commando crawled	……Crawled (using hands and knees)
……Pulled up into stand using furniture	……Walked sideways while holding on to furniture
……Stood alone	……Took a few steps by themselves
……Walked well without holding on	……Able to get up into a chair or car seat without help
……Able to step up one step	……Able to jump with both feet
……Fed self using fingers	……Babbled (made sounds that were not words)
……Talked in single words	……Talked in 2-3 word sentences

MEDICAL (Please circle the following)

Does (s)he appear to hear well?	Yes	No	Do Not Know
Does (s)he appear to see well?	Yes	No	Do Not Know
Does your child have a history of chronic ear infections?	Yes	No	Do Not Know
Does your child have seizures (convulsions)?	Yes	No	Do Not Know
Does your child have allergies?	Yes	No	Do Not Know
Does your child have difficulty eating?	Yes	No	Do Not Know

If yes, what kind? Vomiting, gagging, chewing, swallowing

What medications does your child take?.....

Give the names of previous hospitals, doctors, or therapists that have seen your child. (See page 3 to provide school contacts.)

Name of child's *PRIMARY doctor or clinic:*
Address:
Telephone number: Fax number:

Consulting Physicians, therapists

Name	Service (what specialty)	Telephone number
……	……	……
……	……	……
……	……	……

County In Which You Reside

Please answer the following questions if they are applicable to your child Child's present school Grade

School location (city)

Has your child been tested at school?

What were you told about the results?

What special services does your child receive at school?

What Special Education label(s) (e.g., LLD, Speech Handicapped, or MR) are used to describe your child's problem?

Does your child receive any private help outside of school?

If so, with whom, what, and how often?

If your child is too young to be in school, is he/she in a Mother's Day Out program? Day Care? with a Nanny? (circle one)

Please describe your concerns about your child. If you were referred by a professional please give the name. What questions would you like answered with this evaluation? If needed, continue on the back of this page or attach a page to this.

Name of person completing this form:

Relationship to child:

Date this form was completed:

Authorization to Disclose Protected Health Information

FROM Deirdre McDowell, PT, PCS
Deirdre McDowell, PLLC
811 Arlington Street • Houston, Texas 77007

This form is to confirm your authorization to disclose your child's protected health information to his/her **pediatrician of record**. You may request non-release with this form by writing "none" in the "This information may be disclosed TO…" paragraph below.

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name (first, middle, last and nickname):

Date of Birth:

I authorize the following to disclose the above individual's health information:

Deirdre McDowell, PT, PCS
Physical Therapist
811 Arlington Street
Houston, Texas 77007

This information may be disclosed TO my child's pediatrician:

Name:

Address:

Purpose of disclosure: To share medical records.

Please release the following:

	Medical Evaluation report
	Laboratory Results
	Other specified:

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient/patient representative is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of protected health information described in this form with the people and/or organizations named in this form. If I have questions about disclosure of my health information, I may contact Deirdre McDowell, Owner/Privacy Official, for Deirdre McDowell PLLC.

Patient or Parent's/Guardian's Signature:

Patient or Parent's/Guardian's Printed Name:

Relationship to Patient: Date:

We do NOT share our records with any school or any other professional without your specific separate authorization to do so. That authorization will be obtained if/when necessary. If you choose, you may complete that authorization at the time of the parent conference or after you have reviewed the report. You will receive an exact copy of the original report that you can copy and share as you wish.

IF THERE IS ANY ADDITIONAL INFORMATION OR CONCERN YOU WOULD LIKE TO SHARE PLEASE DO SO ON THIS PAGE

Feel free to include questions you would like to ask