UCLA Pediatric Rehabilitation Parent Questionnaire

Contact Information

Child's Preferred Name or Nick Name: ______________________________ Date: ______________

Name of Parent(s): ______________ (*Mother/Guardian*) ______________ (*Father/Guardian*) Home Phone: ______________

Contact Numbers: ______________ (*Cell Phone 1*) ______________ (*Cell Phone 2*) ______________ (*Work Phone*)

Concerns and Goals

What are your main concerns about your child? ____

What are your goals for physical therapy? ____

Birth and Medical History

Gestational Age: ________ weeks Birth Weight: ____________

Please check all that apply:

Baby was ☐ full term ☐ premature ☐ spent time in intensive care

Delivery was ☐ vaginal ☐ a planned c-section ☐ an emergency c-section

☐ breech ☐ required suction ☐ required forceps

Child is ☐ a twin or part of a multiple birth

Were there any complications of the pregnancy or birth? If yes, please describe.

Has your child ever had any of the following? Please check those that apply.

☐ Heart Problems ☐ Stomach Problems/Reflux ☐ Rash/Skin Problems

☐ Cancer ☐ Seizures ☐ Dislike of certain textures/food

☐ Broken Bones ☐ Breathing Problems ☐ Difficulty eating or swallowing

☐ Brain Injuries ☐ Ear Infections/Other Infections ☐Difficulty following instructions

☐ Sadness or hopelessness ☐ Attempts to harm self or others

Is your child taking any medications? ☐ Yes ☐ No If yes, please list all medications.

Name of Medication	Dosage	Frequency
1.		
2.		
3.		

Please turn page over and continue

Medical History, Continued

Has your child ever had any of the following?	Yes	No	If yes, please specify and list:
Diagnoses of any medical conditions			
Surgical procedures			
Hospitalizations			
Allergies (including medication, food or latex)			
Special testing (x-ray, MRI, ultrasound, CT scan, swallow study, genetic testing, etc)?			
Adaptive equipment (wheelchair, walker, braces, special eating utensils, etc.)			
Physical Therapy, Occupational Therapy, Speech Therapy			*If yes, which services, when, and where?*
Has your child fallen in the last 12 months?			*How many times?* *Was your child injured?*

Social History

Who does your child live with?	

Child is ☐ breast fed ☐ bottle fed ☐ fed via NG/NJ tube ☐ eating solids ☐ ____________________

Please circle yes or no to the following questions:			***If yes, please specify:***
Does your child attend school or daycare?	Yes	No	*Where:* *Grade:* *Hours/Day:*
Does your child have a nanny or babysitter?	Yes	No	*Name:* *Hours/Week:*
Will anyone else be bringing your child to therapy other than a legal guardian?	Yes	No	*Name & Relation:* *(Consent needs to be signed prior to this happening)*
Are there any siblings?	Yes	No	*Names & Ages:*
Is there any other pertinent information we should know about your child?	Yes	No	

UCLA Health System

PATIENT EDUCATION ASSESSMENT

Date: ________________

In order to help us in meeting your education needs, please take the time to answer the questions below.

Person completing the form: ☐ **Patient** ☐ **Family** ☐ **Significant Other** ☐ **Healthcare Professional**

1. **Is English your primary language?** ☐ **Yes** ☐ **No**

   Do you have another language in which it is easier for you to communicate? Preferred language: ______________________________ ☐ **Yes** ☐ **No**

2. **Do you have any problems with your vision or hearing that might affect how we teach you? If yes, please explain:** ☐ **Yes** ☐ **No**

   ____

   ____

   ____

3. **How would you prefer to receive information regarding your care? (Check all that apply):** ☐ **Written** ☐ **Verbal** ☐ **Demonstrate**

   ☐ **Other:** ____

4. **Do you have any beliefs or practices that might affect how we teach you? If yes, please explain (such as religious, cultural, or spiritual):** ☐ **Yes** ☐ **No**

   ____

   ____

5. **Are you ready to receive health instruction?** ☐ **Yes** ☐ **No**

   If no, please explain: ____

   ____

6. **Comments:** ____

____

____

____

____

____

____

____

UCLA Health System

Outpatient Rehabilitation | Santa Monica – 15th St.

1260 15th Street - Suite 900 | Santa Monica, CA 90404
Telephone: (310) 319-4646
www.rehab.ucla.edu

WELCOME!

Welcome to UCLA Outpatient Rehabilitation Services. We are pleased that you and your physician have chosen UCLA to meet your rehabilitation needs. Your primary therapist is ______________________, and your first appointment is ______________________________.

We offer a team approach, involving the primary therapist and other skilled staff members. Your primary therapist will coordinate your care, and you may be seen by other team members for the best possible outcome.

Your involvement in this treatment process is important! Your therapist will evaluate you and design a program to address your specific problems. After evaluation, you, your therapist and your physician will determine the number of visits needed to reach your goals. The goals and number of visits needed to achieve them will be reviewed with you on a regular basis and may change from the number initially set. Regular attendance and following the exercises and recommendations of your therapist will help you achieve your goals.

PAYMENTS

You are responsible for services not covered by your insurance. Some carriers require co-payments be paid each visit. For those patients with a deductible and coinsurance, Patient Business Services will bill your insurance first and then bill you if there is a remaining balance. Patients without insurance coverage will be asked for payment at the time services are rendered.

SPLINTS/DEVICES

If you receive a splint, orthotic or prosthetic device and are having fitting problems, please contact us. Some circumstances may require a return visit to your physician.

PARKING

Self-parking is available in the ground floor of our building. Rates are posted at the entrance. Metered street parking and city lot parking is available; read posted signs carefully.

SCHEDULING

Prior to scheduling your first visit, we must have a signed physician order in the department. The therapist will determine the number of visits, the length of the visits and with whom to schedule your appointments.

If you must cancel or change an appointment, please contact us at least 24 hours prior to the scheduled time. **Cancellations within 24 hours of the appointment may result in a late cancellation fee.**

If your insurance is Medicare, your physician will be required to submit a request for continued care every 30-90 calendar days. Without this new prescription from your physician, you will be discharged from therapy.

Other reasons to be discharged from therapy include the following:

- Lack of current order
- By order of your physician
- "No showing" for an appointment and not contacting us within two working days.
- By missing two scheduled appointments without valid reason
- Gap in attendance of more than 30 days
- Intervening acute medical problem or surgery
- Inability to participate in therapy
- Lack of measurable and sustainable goals
- Attaining treatment goals
- Insurance company fails to authorize additional treatments

MEDICAL RECORDS

If you would like a copy of your treatment notes, you must provide a written request. Request should be addressed to:

UCLA Medical Correspondence
10833 Le Conte Ave., Room BH-225
Los Angeles, CA 90095-1677
(310) 825-6021 Telephone
(310) 825-3356 Fax

There may be a charge for providing this record.

WE LOOK FORWARD TO WORKING WITH YOU TO HELP YOU REACH YOUR FULL POTENTIAL!