IT'S ABILITY
Pediatric Physical Therapy

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# WHEELCHAIR AND ASSISTIVE TECHNOLOGY INTAKE

| Client's Last Name | Client's First Name | Date of Birth |
|---|---|---|
| Phone Number | Address | |
| Primary Care Physician | Who referred you for an Equipment Evaluation? | |
| Preferred Equipment Provider | Phone/Address of Provider | |
| Other doctors and healthcare providers involved in your care (orthopedist, physiatrist, etc.) | | |
| Area Agency involved in funding for equipment or home modifications (if applicable) | | |
| Area Agency Contact Person/Phone Number (if applicable) | | |

**Diagnosis:** _____

**EQUIPMENT NEEDED:**

_____

_____

**EQUIPMENT AND ORTHOTIC HISTORY**

Please list any equipment (wheelchair, walker, bath chair, lift, hospital bed, etc.) and any orthotics (AFOs, Back Brace, etc.) that is used with the approximate date this equipment/orthotic was obtained in addition to the vender/orthotist:

| Equipment/Orthotic | Date Obtained | Vender/Orthotist | Equipment/Orthotic | Date Obtained | Vender/Orthotist |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

What difficulties are being experienced with current equipment?_____

_____

_____

**HISTORY**

1) Who does the client live with? ❑Mother ❑Father ❑Sibling(s) ❑Grandparent(s) ❑Pet(s) Other(s):_____

2) Who are the client's legal guardians? _____

3) What are the daily activities of the client? _____

4) Does the client have pain? ❑YES ❑ NO ❑ UNSURE ❑OTHER:_____

5) If the client does have pain, please answer the following:

a. When does he/she have pain? (check all that apply) ❑Morning ❑Day ❑Evening ❑Night ❑Other:_____

b. How often does he/she have pain? _____Please Explain_____

c. Where does he/she experience pain? _____

d. What makes his/her pain worse and/or causes the pain? _____

_____

e. What makes his/her pain better and/or stops the pain?_____

_____

**SURGICAL HISTORY**

Please list any surgeries with the dates they were performed (approximate dates are fine).

| Surgery | Date | Surgery | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

ADDITIONAL INFORMATION or SPECIAL REQUIREMENTS (if applicable):

_____

_____

_____

_____ _____

Person Completing this Form Relationship to Client

## INSURANCE INFORMATION

Person Responsible for Payment: _____

Primary Insurance: _____

Address: _____

ID#: _____

Group#:_____

Name of Subscriber: _____ Employed By:_____

Secondary Insurance:_____

Address: _____

ID#: _____

Group#:_____

Name of Subscriber: _____ Employed By:_____

Medicaid#: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

**I give permission for IT'S ABILITY, to evaluate and treat the above client, to submit claims to the above named insurance carrier(s) for physical therapy assessment and equipment management services and authorize the release of any medical information to process this claim. I also authorize payment of medical benefits to IT'S ABILITY for physical therapy services.**

Patient/Guardian Signature:_____Date:_____/_____/_____