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	Parent/Guardian	
Preferred Equipment Provider	Email of Parent/Guardian (Phone if Different than Above)	
DIAGNOSIS	Caregiver Name/Phone (if Different than Above)	
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 and Email Address		

EQUIPMENT NEEDED:

_____

_____

What difficulties are being experienced with current equipment?_____

_____

_____

CURRENT EQUIPMENT

Please list any equipment (wheelchair, walker, bath chair, lift, hospital bed, 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**

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:_____

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, including information provided to equipment vendors. I also authorize payment of medical benefits to IT'S ABILITY for physical therapy services.

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