MRN #: Allergies:

Medications:

Apple Tree Early Intervention Center
5851 Newman
Cypress Ca. 90630
(714) 826-4957


**New Patient Information**

Name: ______________________________ DOB: _____________________

SSN: _______________________________ Phone: ____________________

Address: ______________________________________________________________
(Street) (City) (Zip)

Email Address: _________________________________________________________

Parent Information:

Father's Name: _______________________ DOB: _____________________

SSN:_________________________________ Phone:_____________________

Address: ______________________________________________________________
(Street) (City) (Zip)

Employer: _____________________________________________________________

Mother's Name: _______________________ DOB: _____________________

SSN:_________________________________ Phone:_____________________

Address: ______________________________________________________________
(Street) (City) (Zip)

Employer: _____________________________________________________________

Emergency Contact:

Name: _______________________________ Phone:_____________________

Relationship to patient:_________________________________________________

Insurance Coverage:

Provider: _________________________________ Phone: _____________________

Member ID: ____________________

MRN #:

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# Patient Health History Questionnaire

Patient Name: ______________________ Date: ____________ DOB: __________

Birth History:

Delivery: □ Vaginal □ Cesarean. If cesarean, why? ___________________________

Was the baby born full term? □ Yes □ No. If no, how may week? _________________

Did mother have any health problems during pregnancy? □Yes □No. Explain ________

______________________________________________________________________

During pregnancy did mother:

Smoke: □Yes □No Drink alcohol: □Yes □No Take drugs: □Yes □No

If yes, please explain_______________________________________________

Where there any concerns with the child's health at birth? □Yes □No Explain. ______

______________________________________________________________________

Did your child require a hospital stay longer than 3 days? □Yes □No Explain. _______

______________________________________________________________________

General Health:

Please indicate any diagnosis your child has received. ___________________________

Do you consider your child to be in good health? □Yes □No Explain. ______________

______________________________________________________________________

Has your child had any surgery? □Yes □No. Explain. ___________________________

______________________________________________________________________

Has your child ever been hospitalized? □Yes □No Explain. ________________________

______________________________________________________________________

Does your child have any allergies? Please include allergies to tape/adhesive □Yes □No.

Explain.______________________________________________________________

Are your child's immunizations current? □Yes □No. Explain. ____________________

Please list all medications your child is currently taking. _________________________

______________________________________________________________________

Past History: Does your child have or has he/she every had:

| | |
|---|---|
| Chicken Pox □Yes □No | Anemia □Yes □No |
| Ear infections □Yes □No | Blood transfusion □Yes □No |
| Hearing problems □Yes □No | Frequent abdominal pain □Yes □No |
| Vision problems □Yes □No | Frequent constipation □Yes □No |
| Heart problem □Yes □No | Bladder or kidney infection □Yes □No |
| Asthma or respiratory problem □Yes □No | Seizures □Yes □No |
| Chronic skin problems □Yes □No | Frequent headaches □Yes □No |
| Diabetes □Yes □No | Joint or bone problems □Yes □No |

in. ______________________________________________

______________________________________________

______________________________________________________________________

______________________________ ______________________

**Parent of Minor Child Signature** **Date**

PATIENT'S NAME: ______________________________________

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**Behavior**

Do you have any concerns with regards to your child's mood or behavior? If so, what are your concerns?

How would you rate how serious this concern feels to you?

Describe your child's unique strengths and qualities:

How would you describe your relationship with your child?

**Forms of Discipline used in the home:** ☐Time Out☐ Ignoring ☐Rewards/Incentives Physical ☐Punishment ☐Redirection ☐Communication

**Interaction:** ☐Slow to warm ☐Timid ☐Playful ☐Self-Directed Play skills ☐No Interaction

**Mood:** ☐Content ☐ Irritable☐ Angry☐ Anxious/ Fearful☐ Other: ☐

**Attention:** ☐Excellent ☐ Fair ☐Poor ☐Other: ☐

**Affect:** ☐ Appropriate ☐ Inappropriate ☐ Labile ☐ Constricted ☐ Flat

**Participation:** ☐ Always Cooperative ☐ Mostly Cooperative ☐ Mostly Uncooperative ☐ Always Uncooperative ☐

**Directions:** ☐ Always Follows Direction ☐ Mostly follows directions ☐ Does not follow directions

**Challenging Behaviors:** ☐Aggressive ☐Tantrums ☐ Elopes/wanders ☐ Refusal/Turns Away ☐ Arches Back ☐Spitting ☐ Kicking ☐ Hitting ☐Other:

**Mark the box that best describes your approach to discipline:** ☐ Set firm boundaries and consistently follow through with boundaries set ☐ Set boundaries, but give in when child is persistent and tantrums ☐ Don't set boundaries
☐ Communicate expected behavior and assist with follow through

**Play Behaviors:** ☐Plays alone ☐Plays alongside his/her peers ☐Plays with his/her peers ☐Lines toys up ☐Plays with toys in a variety of ways ☐ Notices toys but doesn't play with them

**Affection:** ☐Enjoys Physical touch ☐Does not like/resist touch ☐ Clingy

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____1. **CONSENT:** I consent to therapy evaluation and treatment at Apple Tree Early Intervention Center Inc. I know if I have any questions about my care, I should be sure to ask the therapist about them. I know it is up to me to inform the therapist/staff about any health problems or allergies I have. I must also tell the therapist/staff about drugs or medications I am taking.

____2. **RELEASE OF INFORMATION:** Apple Tree Early Intervention Center Inc. releases patient health care information for purposes of treatment or payment, or to other health care organizations, as explained in our HIPAA Notice of Privacy Practice. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

____3. **INSURANCE:** I authorize the staff Apple Tree Early Intervention Center Inc. to review my insurance coverage with my insurance company. I understand that my insurance benefits are only a quote of benefits and not a guarantee of payment. I understand that what I am quoted by Apple Tree and/or my insurance company may differ from what I may owe at the conclusion of therapy. I understand it is my responsibility as the patient to know my insurance coverage. I authorize payment of my insurance benefits to be made directly to Apple Tree Early Intervention Center Inc. I agree to pay in full any and all charges not covered by insurance or other benefits. I understand that it is unlawful Apple Tree Early Intervention Center Inc. to waive co-pays, co-insurances, and deductibles that are my responsibility. For any returned check, there will be a $25.00 fee added to my responsibility that will be included in your bill. If I do not pay my bill in the specified timeframe, then my balance will be sent to a collection agency and a 35% percent fee will be added to the unpaid balance and will be my responsibility.

____4. **NOTICE OF PRIVACY PRACTICE:** I have read the Apple Tree Early Intervention Center Inc. Statement of Privacy Notice located on the back of this form and I understand that a copy of the notice will be provided to me upon my request.

____5. **CANCEL/NO SHOW/LATE POLICY:** If you must cancel your scheduled appointment, a 24-hour notice is required. **Cancels with a less than 24-hour notice and no shows will result in a $25.00 fee applied to your account.** If you arrive 10 minutes or more late for your appointment, your therapist may not have the time to treat you or your therapy time may be reduced.

I certify that any and all information provided by me in furtherance of my application for health care benefits are true. It has been explained to me, and all of my questions about the form have been answered. I understand its contents.

______________________________________________________________________________

**Parent of Minor Child Signature/Date** **Patient's Representative Signature/Date**

______________________________________________________________________________

**Witness/Date** **Relationship to Patient**

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We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. We may disclose your health information to your insurance provider or the purpose of payment or health care operations. We may disclose your health information as necessary to comply with State Workers' Compensation Laws. We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure. We may disclose your health information in the course of any administrative or judicial proceeding. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes. We may disclose your health information to coroners or medical examiners. We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues. We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board. It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public. We may disclose your health information for military, national security, prisoner and government benefits purposes. We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment." We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.

- You have the right to inspect and copy your health information.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by us.

- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (661) 288-0300. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (661) 288-0300. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.
If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Apple Tree Early Intervention Center Inc. with authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice Please contact the Privacy Officer, Michelle Eckard, RN, Vice President at 661.288.0300 if you have any questions regarding our policies concerning protected health information (PHI).