Pediatric Guidelines & Arrival Policy

611 E Fairview Ave., Olivia, MN 56277
(p) 320.523.3470 (f) 320.523.3429

Our therapists are committed to working with your child on an individualized plan of care to achieve their highest level of function in all environments.

In order to receive the maximum benefit from their rehabilitation program, it is important to understand and comply with the following guidelines:

- *Follow through and return any home programs that are developed to meet the child's needs; you make the greatest difference in a child's life! Your insurance may require proof of your participation in your child's home program.*
- *Please do not let siblings come into the rehab gym or treatment room. BST is not responsible for the safety of the children we are not serving.*
- *It is important that your child attends therapy every scheduled day and have needs for rest, food, diaper changes etc. met by arrival.*
- *If the child is sick, or has had a fever greater than 100 degrees F in the last 24 hours, please keep him/her home.*
- *If head lice has been contracted by the child, they must be cleared by a medical doctor before attending therapy.*
- *Notify the clinic 24 hours prior to your scheduled appointment if the child is unable to attend.*
- *Inform the front desk staff of upcoming physician appointments or any other scheduling conflicts.*
- *In addition, patients may be subject to discharge from therapy services when they fail to arrive to three scheduled appointments.*
- *BST asks for flexibility with scheduling multiple disciplines and times.*
- *BST asks that you please drop off and pick up your child on time as every minute with your therapist counts!*
- *At times it may be necessary for Big Stone Therapies, Inc. to change or reschedule therapy appointment(s). By signing this agreement I give consent to allow the staff at Big Stone Therapies, Inc. to contact me by phone, email, at home or work regarding information about therapy appointment(s) including leaving messages.*

BST expects families and caregivers to take an active role in rehabilitation. Please don't hesitate to ask questions and observe treatments. Your compliance with this policy will ensure that we can provide the best therapy experience.

I understand and agree to the following policy as stated above.

_____ _____

Parent/Guardian Signature Date

Pediatric Medical History Form

611 E. Fairview Ave Olivia, MN 56277
(p) 320.523.3470(f) 320.523.3429

To better acquaint your therapist with your child's medical history, you have been asked to complete this health questionnaire. Your answers are strictly confidential and help your therapist perform a detailed evaluation.

Name _____ Height _____ Weight_____ DOB _____

Mother's Name _____ Father's Name _____

Child lives with _____ Siblings (number and age(s)) _____

Does your child have a medical diagnosis? Yes/No (circle) If yes, please list _____

Chief Complaint _____

_____

Does your child use any assistive devices? (i.e. wheel chair, communication device) Yes/No (circle)

If yes, please list _____

----------Birth History----------

Delivery Method _____ Any complications during birth or pregnancy? If yes, please list _____

Was your child born full term? Yes/No (circle) If no, how many week pre-mature? _____

----------School Services----------

Does your child attend school? Yes/No (circle) If yes, where? _____ Grade _____

Name of teacher? _____ Special requirements at school: _____

Does your child receive school based therapy services? Yes/No (circle) If yes, what? _____

Does your child have an IEP? Yes/No (circle)

----------Motor Development----------

Please indicate when your child accomplished the following. Select NA where applicable.

Rolled over	_____	NA	Stood alone	_____	NA
Walked	_____	NA	Used utensils to feed self	_____	NA
Used the toilet	_____	NA	Single words	_____	NA
Sat independently	_____	NA	Crawled	_____	NA
Finger fed self	_____	NA	Dressed self	_____	NA
Colored	_____	NA	Short Phrases	_____	NA

Additional comments: _____

----------Gross Motor----------

Does your child complain of any pain or discomfort? Yes/No (circle) If yes, where? _____

Do you have any concerns with the way your child walks or runs? Yes/No (circle) If yes, explain _____

----------Communication Methods----------

How does your child communicate? (circle all that apply)

Crying	Pointing with finger	Sign language	Words	Pulling/directing to want/need
Phrases	Electronic Talking Devices	Sentences	Picture Communication	

(Please continue on second page)

Pediatric Medical History Form

611 E. Fairview Ave Olivia, MN 56277
(p) 320.523.3470(f) 320.523.3429

----------Medical History----------

Does your child currently have any of the following conditions? (circle all that apply)

Allergies	Latex Sensitivity	Hospitalizations	Broken Bones	Serious Illnesses
Surgeries	Dislocations	Sprains	Falls	Head Injuries
Other injuries	Sleep Difficulties	Vision Difficulties	Seizures	

If yes, please explain _____

List all prescription and/or over the counter medications your child had recently taken or is currently taking.

☐ See attached prescription list.

_____

_____

Do you have a family history of any of the following? (circle all that apply)

Asthma	Cancer	Circulation Issues	Heart problems	Anxiety	Diabetes
Headaches	Pacemaker	High Cholesterol	Dizziness/Vertigo	High/Low BP	Kidney Disease
Liver Disorder	Lung Disorder	Lymphedema	Neurological Disorders	Pacemaker	Osteoporosis
Rheumatoid Arthritis		Renal Dysfunction	Thyroid Problem	Stroke	Unwanted bladder or bowel loss

Other _____

Any additional comments _____

_____

_____

_____

Patient Signature _____ Date _____

Parent/Guardian signature if patient is under 18 years of age