PEDIATRIC THERAPY SERVICES | where children learn and leap

TheraSuit Method® Intake

Date: ___________________

Patient Information:

Patient Name: ____ Date of Birth: ____________________

Primary Diagnosis: ____ Gender: male or female

Parent/Legal Guardian Names: ____

Address: ____

Primary Phone Number: ______________________ Alternate Phone Number: ____________________

Email address: ____________________________________ Primary language: ___________________

Emergency Contact and Phone Number: ____

Primary Insurance Provider: __________________ Secondary Insurance Provider __________________

Physician Information

Primary Care Pediatrician: ____________________________ Phone #: ______________________________

Physician's Address: ____

Physician's Phone Number: ____

MEDICAL HISTORY:

List history of all Diagnoses:

____

____

Pregnancy Complications:

____

____

Birth History:

Gestational age: ____

Vaginal or Cesarean section delivery: ____

Weight: ____

APGAR scores: ____

Complications: ____

NICU stay: ____

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CUMULATIVE MEDICAL AND SURGICAL HISTORY:

Genetic disorder: ____
Metabolic disorder (Muscular dystrophy?): ____
Mitochondrial disorder: ____
Bone Disorder (osteopenia/osteoporosis) /Fractures (body part, date, how occurred, surgery or casting and how long):

____

Hip Subluxation or dislocation (left or right)

* must provide an x-ray report and medical release from orthopedic physician:

____

Scoliosis (Location/Degree):

* must provide an x-ray report and medical release from orthopedic physician:

____

Fixed contractures (location): ____

High blood pressure: ____
Heart conditions or Heart surgeries (date): ____
Seizures (type, frequency, date of most recent, controlled with medication):

*must provide written medical release from Neurologist

____

Diabetes (Type): ____
Shunts (Hydrocephalus) (Date, revisions):

____

Kidney issues (catheter):

____

Botox/Phenol injections (location/dates):

____

____

Serial casting (dates):

____

____

Selective Dorsal Rhizotomy (Date/surgeon):

____

____

Muscle lengthening (location/dates/surgeon):

____

Breathing issues:

G-tube/Tracheal Tube/Feeding Problems/Restrictions:

____

Sensation / Loss of feeling (location):

____

Vision / Hearing (glasses/ hearing aids):

____

Other:

____

____

Child's Specialists:

Specialists	Last Appointment/Recommendations	Next Appointment
____________	____________________________	___________
____________	____________________________	___________
____________	____________________________	___________
____________	____________________________	___________

Current Medications:

Name	Dose	Frequency	Purpose	Method (Oral, Nebulizer, etc)
____________	_______	________	________	________
____________	_______	________	________	________
____________	_______	________	________	________
____________	_______	________	________	________

Allergies:

____

Dietary Restrictions:

____

Medical equipment (wheelchair, standers, bath chair, walker, crutches, canes, braces, splints, AAC device):

____

____

Therapy (what type, where, frequency)

- Occupational Therapy ____________________
- Physical Therapy ____________________
- Speech Therapy ____________________
- Applied Behavior Analysis ____________________
- Feeding Therapy ____________________
- Intensive Therapy (TheraSuit Method or CME, including date(s))

  ____

Child's function:

Check the following that your child CAN do:

- Rolling from back to stomach (over left and right side?)
- Rolling from stomach to back (over left and right side?)
- Sitting
- Transition from lying down to sitting
- Hands and knees
- Crawling (advances arms and legs at the same time OR alternating arms and legs)
- Pull to stand at a support
- Side stepping at a support (to the left and right direction?)
- Standing at a support
- Standing not at a support
- Walking with aid (with gait trainer, walker, or canes?)
  - How far?
- Walking without aid
  - How far?

Communication:

How do you communicate with your child? ____________________

How does your child communicate with you? ____________________

- Can your child follow one step commands? ____________________
- Can your child follow two step commands (first . . .then . . .)? ____________________
- Can your child follow complex commands? ____________________
- Can you child move head, arm or leg upon request? ____________________

What motivates your child? (what toys, bubbles, songs, TV, praise)

____

Goals:

What are your goals for the Intensive Strengthening Program?

____

____

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Measurements:
Please provide the following measurements:

- Height: ______________________________
- Weight: ______________________________
- Shoe size with orthotics: ______________________________
- Shoe size without orthotics: ______________________________
- Circumference of
    - Chest (around nipple line): ______________________________
    - Waist (around smallest part of waist near belly button): ______________
    - Hips (around largest part of waist): ______________________________
    - Thigh (middle of thigh): ______________________________

If x-ray reports were indicated above based on child's medical history, an x-ray must be dated within 6 months of start date.

Please submit completed application. Upon review, you will be contacted to discuss the TheraSuit Method® and scheduling. If you have any questions, please call (813) 662-1060.

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<u>TheraSuit Method® Expectations</u>

TheraSuit Method® utilizes an intense, specific, and individualized strengthening program to improve the child's functional movement patterns based on the their impairments. The child's evaluating therapists will perform a thorough evaluation, outline the child's impairments, and discuss progression of functional movement patterns with the use of TheraSuit Method®. In addition, the evaluating therapist and parent/legal guardian will develop realistic and appropriate goals related to these findings in order to optimize the child's potential with the use of TheraSuit Method®.

Please find more information related to TheraSuit Method® at www.suittherapy.com.

By signing below, I certify that I have read this form, and that I am the child's legal guardian to accept its terms.

______________________________	______________________
Print name of parent/legal guardian	Relationship to child
______________________________	______________________
Signature of parent/legal guardian	Date

TheraSuit Method® Nutrition Guidelines

Nutrition is in an integral part of your child's success during the intensive strengthening program and can contribute to 50% of progress. Proper nutrition is imperative as it aides in the synapses responsible for making changes in the brain.

Please provide your children with nutrient dense snacks to help maintain energy levels throughout the scheduled session.

The following smoothie is recommended:

- ½ avocado
- 1 cup dark fruit
- ½ banana
- 2 tablespoons almond milk/goat milk
- 2 scoops chia seed/flax seed/coconut oil/fish oil

Alternate snack ideas (we suggest finger foods that can be incorporated into session):

- Fresh fruit and veggies
- Nuts
- Cheese
- Sandwich that can be easily pulled apart
- Please avoid high sugar snacks such as candy and cookies

Nutrient dense options for G-tube fed children:

- Nourish
- Kate Farms

Don't forget to keep your child hydrated, a water bottle is recommended

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TheraSuit Method® Contract

Please read and initial indicating your full understanding and agreement with the following items prior to the start of your child's first intensive strengthening program.

	Initials
1) I agree to bring my child to ALL scheduled appointments for times and dates agreed upon. The program is individualized to your child and based on 100% attendance for the full duration.	
2) I agree to arrive ON TIME to all scheduled sessions.	
3) I agree to bring HEALTHY snacks and water for my child during each of their sessions in order to supplement for energy expenditure and additional calories burned during the intensive program (please see hand out on nutrition). Your child will be expending significantly more calories and energy during this program and it is imperative they replenish with a sufficient, healthy snack throughout each session.	
4) I agree to dress my child in comfortable and lightweight clothes, including long pants and socks. If my child has long hair, I agree to keep it tied back.	
5) I agree to sign a release giving permission for my child to be videotaped and photographed. This will be primarily used to reveal progress before and after completing the program.	
6) I agree to sign a release giving permission for data obtained during the program to be used in current or future research studies.	
7) I agree to comply with our policy of no use of technology during the program as use of technology significantly reduces participation and involvement.	
8) I agree to comply with the individualized prescribed home exercise program following completion of the program.	
9) I agree to refrain from having my child participate in another intensive strengthening program for at least 3 months following completion of this program.	

I have reviewed and agree to the above information and requirements for participating in the TheraSuit Method® at Pediatric Therapy Services, Inc.

By signing below, I certify that I have read this form, and that I am the child's legal guardian to accept its terms.

I have received a copy of this form prior to the start of therapy services.

____
Print name of parent/legal guardian

____
Relationship to child

____
Signature of parent/legal guardian

____
Date

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