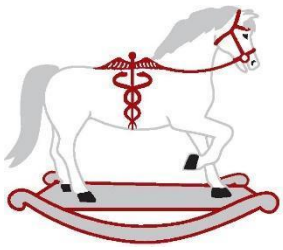


ROCKING HORSE REHAB
Family Wellness Center

256 S Maple Ave. Basking Ridge, NJ 07920 ph 973-731-8588 www.rockinghorserehab.com

Application and Health History

Therapy of Interest: OT__ PT__ SP__ MH__ BT__ AR__

Background Information Today's Date: _____/_____/____

Client's Name: _____ _____/_____/_____ Gender: M F
DOB:

Age: _____years _____ months___ Weight:_____ Hand Preference:
Height: _____ _____ L
R

Mother's Name: _____ Father's Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Mother's Cell Phone:_____ Father's Cell Phone:_____

Email Address:_____

Mother's Occupation: _____ Work No.: _____

Father's Occupation: _____Work No.: _____

Siblings: Age: _____
_____ Age: _____
Age: _____

Referral Source: _____ Language Spoken: _____

Primary Medical Diagnosis: _____

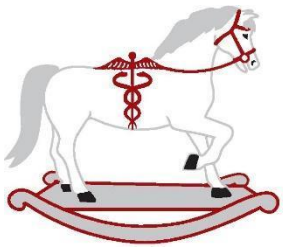
Secondary Medical Diagnosis: _____

Precautions: _____

Insurance Information

Insurance Company: _____Patient ID #: _____

Phone #: _____ Address: _____



ROCKING HORSE REHAB
Family Wellness Center

Birth History

Prenatal care began: _____

Please describe any illness, accidents, or problems relating to the mother or child during and/or after pregnancy:

Medications taken during pregnancy:_____

Tests during pregnancy:
Ultrasound: _____ Amniocentesis: _____ Stress tests: _____Other: _____

Place of Birth: _____Weeks Gestation: ____ Type of Delivery: _____ Length of Labor: _____

Neonatal Period

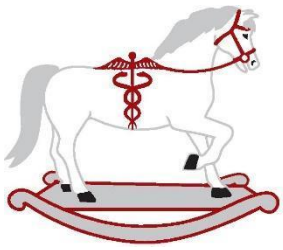
Birth Weight: _____ Apgar Score: _____

Special Treatment in the delivery room: Intubated ( ) Resuscitated ( ) IV placed ( )

Oxygen Length of Stay and treatments received for both mom and child:

Since birth, please give dates and description of any hospitalizations, accidents, illnesses or health concerns:

Please list any medications your child takes on a regular basis:
Medication:_____
Purpose:_____
Times:_____ Amount:_____



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Medical Practitioner's Information: Please include names and phone numbers.

Pediatrician: _____ Phone_____

Hearing: _____ Phone_____

Vision: _____ Phone_____

Neuro: _____ Phone _____

Ortho: _____ Phone _____

Gastro: _____Phone: _____

Education

School Placement _____ Phone No.: _____

Teacher's Name _____ Phone No.: _____

School Schedule: _____

Therapy Services

PT _____ Facility: _____ Phone No.: _____

Frequency & Duration: _____

OT_____ Facility: _____ Phone No.: _____

Frequency & Duration: _____

SLP _____ Facility: _____ Phone No.: _____

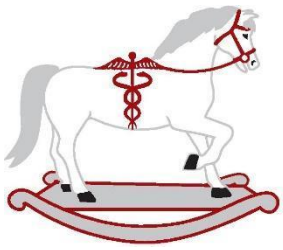
Frequency & Duration: _____

Mental Health__ or Behavioral Health__ Facility:_____ Phone No.: _____

Frequency & Duration: _____

Adaptive Riding or Equine Facilitated activities Facility:_____ Phone No.: _____

Frequency & Duration: _____



ROCKING HORSE REHAB
Family Wellness Center

Home Program Information (if applicable):

Home Program Coordinator: Phone No.: _____

_____ Phone No.: _____

Home Program Tutor:

_____

Total Hours Weekly: _____

Reason for Referral

Oral Motor _____

Feeding _____

Articulation _____

Language _____ Apraxia _____ Hearing _____

MENTAL HEALTH (EFP_____

BEHAVIORAL HEALTH(ABA)_____

Behavior _____ Cognitive _____ Social _____

Vision _____ Gross Motor ___ Fine Motor ____

Sensory____ Focus/ Attention____ Other: _____

Please describe the area of concern indicating when it was first noticed, and development:

_____

_____

_____

_____

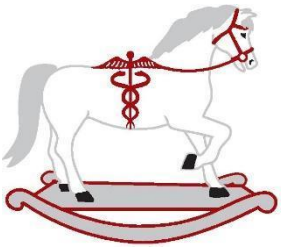
_____

_____

_____

_____

_____



ROCKING HORSE REHAB
Family Wellness Center

Current Skills

Please describe your child's…

Eye contact:

_____

Gestures:

_____

Speech Sounds:

_____

Words:

_____

Sentences:

_____

Behaviors:

_____

Gross Motor Skills:

_____

Fine Motor Skills:

_____

Sensory Processing:

_____

Hearing:

_____

Vision:

_____

Feeding Skills:

_____

Respiration/Circulation:

_____

Psycho/Social Function and Mental Health:

_____

Allergies:

_____

Primary Concerns and Goals:

_____

_____

_____

** Please provide recent IEP, evaluations and/or progress reports.*

Weekdays and times available for treatment services: _____

Name of person completing this form: _____
Relationship: _____
Signature: _____
Date: _____/_____/_____

PHOTO RELEASE

I ☐ DO/ ☐ DO NOT consent to and authorize the use and reproduction by Horizon Pediatric Consultants, LLC, dba Rocking Horse Rehab of any and all photographs and any other audio/visual materials taken of my child for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature:_____Date:_____

Parent or Legal Guardian