WHEAT
Physical Therapy & Wellness
Client specific, evidence based... for lifelong wellness

Pediatric New Patient Paperwork

Patient's Name (as it appears on Insurance Card): _____

Birthdate: _____ **Telephone:** _____

Parent or Legal Guardian: _____

Patient's Social Security #: _____ **Guarantor Social Security #:**_____

Insurance Primary: _____ **Insurance Secondary:** _____

Name of Insured: _____ **Relationship to Patient:** _____

Primary Physician: _____

Reason for Physical Therapy: _____

Do you receive Home Health, Nursery Service, OT, Speech Therapy? _____ **If so, specify.** _____

Consent for Treatment:

Physical Therapy is a healthcare specialty concerned with treating disorders of the musculoskeletal system and its interaction with physical movement. The goal of physical therapy is to restore maximum functional independence to each individual patient before or after surgery. Stretching and strengthening exercises are used to help speed recovery. Our physical therapists work closely with patients to tailor a program that is appropriate for their diagnosis and their rate of recovery. I _____ hereby consent on behalf of my minor child _____ to therapeutic procedures outlined to be performed:
I agree to be evaluated and treated for functional loss due to related nerve, muscle and skeletal dysfunctions and or pain.

I understand that therapeutic procedures can include but are not limited to joint and soft tissue mobilization; clinic and home exercises.

I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time.

I understand that I may consult with other therapists or physicians at any time regarding my condition.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of m existing injury or condition. This discomfort is usually temporary; if it does not subside in 48 hours, I agree to contact my physical therapist.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical alternatives with my physician or primary care provider.

_____ _____ _____

PRINT NAME **SIGN** **DATE**