KIDSPACE

Adaptive Play and Wellness

www.kidspaceadaptiveplay.com

469 Buckland Road
South Windsor, CT
06074
phone (860) 432-9923
fax (860) 432-7553

Miela Gruber–Cooley ND— Registration Form

(Please Print)

Today's Date:_____ PCP:_____

Patient Information

Patient Name: (Last, First, Middle) _____

Parent/Guardian's Name(s): _____

Home Phone: (_____)_____-_____ Cell: (_____)_____-_____

E-mail address:_____

Date of Birth:___/_____/____ Male___ Female___

Street Address:_____ P.O. Box_____

City:_____ State:_____ Zip Code:_____

Occupation:_____

Employer name & Phone:_____

Chose Dr. Gruber because/ Referred by: _____

_____

In Case of Emergency

Name of local friend or relative (not living at same address):_____

Relationship to patient_____ Home Phone (_____)_____-_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Forest Family medicine or insurance company to release any information required to process my claims.

Parent/Guardian signature:_____ Date:_____

AUTHORIZATION FOR SHARING OF MEDICAL AND EDUCATIONAL RECORDS AND/OR PERMISSION TO DISCUSS MEDICAL HISTORY/RECORDS

PATIENT'S NAME_____

CONSENT TO SHARE MEDICAL AND EDUCATIONAL RECORDS AND/OR DISCUSS MEDICAL HISTORY

I consent to the sharing of my medical and educational records with:
NAME: Practitioners at Kidspace Facility
ADDRESS: 479 Buckland Road, South Windsor, CT 06074
PHONE: (860) 432-9923

Patient Signature: _____Date_____

Relationship to Patient, if signed by someone other than Patient_____

Child's name: _____

Birth date: _____ Today's Date: _____

Your name: _____ Relationship to Child: _____

Your Address: _____ Telephone: _____

Are you the legal guardian of this child: Yes _____ No _____

If No, who is and how can we contact them: _____

_____

Do we require the permission of another parent or guardian in addition to your permission:

Yes _____ No _____ If Yes, who is this, and how can we contact them: _____

_____

Consent to Share Information with all practitioners at Kidspace:

I consent to the sharing of my child's healthcare and educational records with the other practitioners at the Kidspace facility.

Signature _____Date _____

NOTE: CHILDREN WILL NOT BE PERMITTED TO PARTICIPATE IN PROGRAMS OR FREE PLAY TIME UNLESS WE HAVE THIS FORM COMPLETED AND SIGNED BY A LEGAL GUARDIAN OF THE CHILD TO BE ENROLLED. IF ASSISTED BY A VISITING THERAPIST, A SECOND FORM WILL BE REQUIRED TO BE COMPLETED BY THE THERAPIST. THANK YOU.

KIDSPACE, Reaching Milestones through Adaptive Play, LLC (KIDSPACE) has agreed to provide the facility and teachers/staff that will provide instructive programs and/or minimally supervised free play time.

Teachers will enlist children and parents in a variety of developmentally stimulating adaptive play programs for their children. During programs and free play time, parents and ancillary therapists invited into the facility by families, will have full responsibility for their children. KIDSPACE will have a staff member on site and during the use of equipment at all times for questions or concerns concerning the facility and its equipment. KIDSPACE does not guarantee the skill or availability of said staff member to supervise their activities or provide therapeutic direction to them or their children during this free play time.

Parents (or representative) are responsible at all times for the conduct, safety and discipline of their children while attending programs, free play or consultations at KIDSPACE, Reaching Milestones through Adaptive Play, LLC and agree that they will not hold the staff of KIDSPACE responsible for any injuries sustained to children or parents while engaged in programs or free play time on the equipment of said facility unless it has been shown to be directly associated to the actions or neglect of a member of the staff of KIDSPACE, Reaching Milestones through Adaptive Play, LLC. Due to space and supervision limitations, siblings cannot be invited to participate unless they are officially enrolled in a program.

CHILDREN'S HEALTH HISTORY FORM

Name: _____

Date of Birth: _____ Age: _____

What are your present Health Concerns for this child?

Please list other providers that you child currently sees. Include name of Primary Health Care Provider/Pediatrician, Chiropractor, Lactation Consultant, specialist, Etc. Include their phone numbers for consult if needed.

Current medication/vitamins:

Herbs/Homeopathy/Home remedies:

Allergies/Reactions to Medications or Vaccinations?

Pregnancy and Birth

Where was your child born? _____

Is this child yours by: Birth ___ Adoption ____ Foster care ____ Step child ____ Other:

How would you describe the child's pregnancy? Indicate any medical problems during pregnancy.

Were there any unusual stresses during the pregnancy?

Did the mother experience any shocks or frights during the pregnancy?

Mother's health/nutrition during pregnancy?

Delivery: Vaginal ___ Caesarean___ Medication during birth (include antibiotics, pain med, etc.):

If Caesarean, why?

Other interventions during birth? _____

Birth Weight _____ Height_____

APGAR score 1 min. _____ 5 min _____

Was the child full term? Yes ____ No_____ If premature, how early? _____

Please indicate any medical problems during the baby's newborn period.

Were there any problems establishing breastfeeding during the newborn period?

How would you describe this child as an infant?

Nutrition and Feeding

Was your child breast-fed?____ If so, how long? _____

At what age were other foods introduced?_____

If formula was used, please indicate at what age it was introduced and what type?
Age: _____ Cows Milk: _____ Soy: _____ Other: _____

Has your child had any feeding/dietary problems? Yes___ No____ Specify:

Are there any dietary restrictions?_____

Does the child have any food cravings/aversions? Yes ___ No ____ Specify:

Does the regularly drink water Yes __ No__ Juice? Yes__ No__ How much?

Soda? Yes__ No__ How much?

Milk? Cow__ Goat__ Rice__ Soy__ Nut__ How much?

Does the child eat three meals a day? _____ Snacks _____

Exercise

Does the child spend time outside daily? Yes___ No___

Do they participate in any sports, dance, martial arts, etc? Yes__ No__ If yes, indicate type/how often?

_____

TV-Hours per day: _____
Computers-Hours per day: _____
Video games-Hours per day: _____
Homework- Hours per day: _____

Do you have concerns about this child's level of activity?

Sleep

Where does the child sleep _____ Hours per night _____ Naps _____

Nightmares _____ Restlessness_____ Insomnia _____

Do you have concerns about this child's sleep habits?

Development

At what age did your child :

Get first teeth _____ Held head upright _____ Sit alone _____

Walk alone _____ Say words _____ Girls only: Age at first menstrual period _____

Dental History

Do you or the child brush their teeth: _____ Has the child seen a dentist: _____

If so, How often: _____ Has child had any dental problems? Please Explain: _____
_____

Does the child have any fillings: _____ If yes- Mercury/amalgam____ Ceramic____ How many?

Illnesses or Conditions the child has had: (please check all that apply)

German measles ___ Mumps ___ Measles ___ Chicken pox ___ Whooping cough ___

Scarlet fever ___ Colic ____ Asthma ___ Allergy ___ Rheumatic fever ___ Eczema ___

Caner ___ Mononucleosis ___ Ear Infection ___ ADHD ___ Anorexia ___ Bulimia ___

Other :

Immunizations

Hepatitis B ___ DPT ___ H. Flu ___ Polio ___ MMR ___ Varicella ___ Other: _____

Were there any reactions to the vaccines?

Habits (Past or Present)

Bed rocking ___ Head banging ___ Thumb sucking ___ High pitched crying ___ Tics ___

Pica ___ Nail biting ___ Ritual behavior ____ What? _____

Picks nose ___ Hurting self ____How? _____

Hurting others ___ How? _____

Hyperactive behavior _____

Changeability (mood swings) ____ Describe _____

Toilet Habits

Any problems toilet training?

Bedwetting?

Bowel movements: How often _____ Consistency _____

Color _____ Rash with BM _____

History of constipation alternating with diarrhea?_____

Other

Bad breath, Bad taste in mouth, Body odor: _____

Stomach pain relieved by food: _____

Stomach pain worsened by food: _____ Any food in particular: _____

Strong craving for sweets or chocolate: _____

Allergies

Dark circle under eyes: _____ Frequent or constant stuffy nose: _____

Cough/throat clearing/hoarseness: ___ Cry or complain of stomach ache between meals: ___

Rectal Itch: ___ Dark or excessive ear wax: ___ Ear itching: ___ Frequent ear infection: ___

Canker sores: ___ Antibiotic treatment: ___ How many? _____

White tongue: ___ Many upper respiratory infections: ____ Rashes: ____ Where: _____

Shortness of breath: ___ Behavior changes after eating: _____

What kind of child is this? How would you describe him/her?

In school?

Child's attitude?

Emotions (Now or Past)

Excessive worry: ___ Hard to express anger: ___ Easily angered: ___ Nervous: ___

Restless: ___ Feels worthless: ___ Feels like killing self: ___ Hurt self in past: ___

Feeling of rage/violence: ___ Trouble getting along with people: ___

Likes to stay alone most of the time: ___ Has trouble being alone: ___ Trouble leaving house: ___

Excess stress for prolonged periods of time: ___ Don't know how to relieve stress: ___

Mood swings: ___ Fearful: ___ Vengeful: ___ Feels like a victim: ___ Crying spells: ___

Depression: ___ Oppositional: ___ Impulsive: ___ Vivid dreams/nightmares: ___

Drives self too hard/perfectionist: ___ Seems apathetic: ___ Messy/disorganized: ___

Unusually neat: ___ Unusual sense of responsibility: ___

Has sustained a loss of someone dear through death or separation: _____

Do you feel child has recovered from that loss: _____

Has child every experienced abuse: _____ Explain if you can:

Has child ever witnessed any violence?

Is child generally: Happy _____ Unhappy _____

Preteen/Teen

Young Women

Age when you started your menstrual period: _____

Period every: ____days Regular? Yes: ___ No:____ Length: _____

Any problems with menstrual period?

Vaginal itch or pain?_____

Urinary tract infections? _____

Any other concerns?_____

Would you like to discuss questions about sexuality or birth control options with me?

Young Men

Any problems (difficult, pain or burning) with urination: _____

Discharge from penis: _____

Lump(s), swelling or pain in testicles: _____

Would you like to discuss questions about sexuality or birth control options with me?

Both young men and women

Are you experiencing unusual pressure from your peers to participate in activities that are unusual or new or uncomfortable for you?

Are you concerned about your future?

Have you experimented with any of the following?

Illicit drug use ___ Prescription pill use ___Alcohol use ___ Cigarettes ___

Sniffing ___ Weight loss pills ___ Caffeine ___

Do you use any of the above regularly? _____Are you concerned?_____

Are you concerned that you are too heavy or too thin?

Do you like food?

Are you afraid you eat too much?

Have you ever made yourself throw up because you thought you ate too much?

Do you ever hurt, cut or burn yourself intentionally?

Do you take more risks than your peers?

DO you ever feel like killing yourself or running away?

How do you feel you are handling pressures at home/school?

Any other questions or concerns you may have for me?

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Dr. Miela Gruber's Office has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Dr. Miela Gruber, ND
(860) 432-9923

I also understand that I am entitled to receive updates upon request if Dr. Miela Gruber's Office amends or changes its Notice of Privacy Practices in a material way.

_____
Signature

_____
Relationship to Patient, if signed by someone other that patient

_____
Date

THIS SECTION IS TO BE COMPLETED BY DR. MIELA GRUBER'S OFFICE, IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.

[ ] Other (specify): _____

_____ _____
Name and title of employee *Date*

A photocopy of this agreement shall be considered as effective as the original.

Summary of Notice of Privacy Practices

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to help you to obtain payment for our services by allowing insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures based on your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information, social security numbers or other financial information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To the law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive a notice of our privacy practices.

A copy of the complete Notice is available upon request.