



Sari Lewis, OTR/L, RCST®

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Scottsdale, AZ 85260

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Phone: (480) 206-6592

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Pediatric Health Information

Name of child: _____ Birth Date: _____ Date: _____

Nicknames of child: _____ Social Sec. # of child: _____

Address: _____ Phone # of parent: () _____

City/State/Zip: _____ Parents Names: _____

Mom's Cell Phone: () _____ Dad's Cell Phone: () _____

Email contact: _____

Referred by: _____

Primary Health Care Provider: _____ Phone: () _____

Permission to consult with primary provider? Please initial. Yes _____ No _____

Emergency Contact/relationship: _____ Phone: () _____

Email of Mom/Dad _____

Birth History

Describe pregnancy: (duration, complications) _____

Describe labor and delivery: (interventions~please include whether induced, use of forceps, vacuum, C-section, etc.) _____

Describe personality, eating and sleeping patterns and any other pertinent information about your child:

What results are you seeking for your child with Craniosacral Therapy treatments? _____

List current medications:

(Please continue to page 2)

Significant Medical History (Include date and treatment received)

Has your child been treated by any other practitioner for any of the symptoms listed? _____

Surgeries/Accidents/Injuries: _____

Any other information that you would like to share: _____

Insurance Information

Name of Policy Holder: _____ Date of Birth: _____

Name of Insurance: _____ Phone #: () _____

Address of Insurance: _____

Policy/group, ID #'s _____

Relationship of patient to policy holder: _____

I understand that Sari Lewis, OTR/L, RCST® will bill my insurance company as a courtesy and that I am ultimately responsible for all charges not covered by my insurance. **If applicable**, I authorize the release of any information necessary to process my insurance claims. I also assign and request payment directly to Sari Lewis, OTR/L, RCST®.

Parent/Guardian Signature

Date

Wellness/Cash Pay Patients

I agree to be financially responsible at the time of service for the full cost of Wellness visits with Sari Lewis, OTR/L, RCST®. I will not, nor will Sari Lewis, OTR/L, RCST® bill any insurance company for the services provided.

I realize that Wellness visits are separate from Occupational or Physical Therapy services. If my child is under care in another therapy program, I will inform Sari Lewis, OTR/L, RCST®.

Parent/Guardian Signature

Date

I give my consent for Sari Lewis, OTR/L, RCST® to treat my minor child.

I agree to hold Sari Lewis, OTR/L, RCST® harmless from any claims, demands, injuries, damages or actions resulting from participation in a Craniosacral Therapy Program with Sari Lewis OTR/L, RCST®.

Parent/Guardian Signature

Date

