Sari Lewis, OTR/L,RCST®

10601 N. Hayden Road, Suite 108
Scottsdale, AZ 85260
www.sarihands.com

Phone: (480) 998-8448 **Fax (480) 451-1352**

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: ( ) _____
Referred by: _____
Primary Health Care Provider: _____Phone: ( )_____
Permission to consult with primary provider? Please initial. Yes_____ No _____
Emergency Contact/relationship: _____ Phone: ( )_____

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**

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