



**Developmental & Rehabilitation Services
TheraSuit Method™ Intensive Program Application**

Prior to completing this application please review *What to Expect* and *Parent Contract* (attached documents)

Child's name: _____ **M:** _____ **F:** _____ **Date of birth:** _____

Parent / Caregiver's name: _____

Address: _____

Phone: Home (_____) _____ **Cell** (_____) _____

E-mail: _____

Has your child received, or is your child currently receiving therapy?

_____ **Yes** _____ **No** **If yes, when and where?** _____ **(attach recent reports)**

1. Diagnosis (List all):

2. Medical / Surgical History:

- **Allergies (Latex? List all):** _____

- **Botox / Phenol Injections (Dates):** _____

- **Inhibitive / Serial Casting (Dates):** _____

- **Fractures (Location / dates):** _____

- **Rhizotomy (Date):** _____

- **Muscle Lengthening (Location / dates):** _____

- **Seizures (Severity and date of last one):** _____

- **Heart Problems / Hypertension / Heart Surgeries:** _____

- **Breathing / Lung Problems (Is your child on any monitors or oxygen? Tracheostomy? Asthma?):**

- **Diabetes (Insulin?):** _____

- **Sensation / Loss of Feeling (Location):** _____

- Scoliosis (Location / Degree): _____

- Vision / Hearing: _____ Glasses _____ Hearing Aides

- Shunts (Hydrocephalus): _____

- G-Tube / Feeding Problems / Restrictions: _____

- Kidney Problems (Catheterized?): _____

Other: _____

3. List the names and phone numbers of specialists who treat your child:

4. List any medication your child is taking and reason for taking it:

5. Child's abilities (check what your child can do):

- Roll over independently
- Sit independently
- Assume sitting independently from lying down
- Crawl
- Stand: _____ holding on _____ independently
- Walk: _____ holding hands _____ independently
- Other: _____

6. List any medical equipment that your child is utilizing (such as braces / splints, standers, walkers -what type, crutches, canes, wheelchairs, etc.):

7. How do you communicate with your child / how do they communicate with you?

8. Is your child able to follow simple commands? ___ Yes ___ No

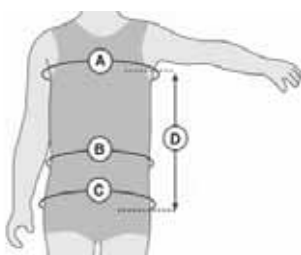
9. Does your physician advise you that your child NOT PARTICIPATE in intensive physical activities?
___ Yes ___ No (Why? Did they mention any contraindications?)

10. Has your child ever been denied therapy at a clinic that provides intensive therapy?
___ Yes ___ No (If yes, explain when and why)

11. What is your child's:

Height: _____ inches Weight: _____ lbs Shoe size _____

Circumferences (measurements) of:



A. Chest: _____ inches

B. Waist: _____ inches

C. Hips: _____ inches

D. Length (underarm to hip): _____ inches

E. Thigh (mid): _____ inches



12. Attach a written hip x-ray report (no older than 6 months)

13. Attach any other available test or therapy reports (x-ray, MRI, CAT scan, EMG, PT, OT, etc.)

Location preferred (please circle one): **Brandon** **St. Petersburg** **First Available**

Fax this completed form to: ACH ThersSuit Method Intensive Program at (727) 767- 8847
or

Mail to: Developmental & Rehabilitation Services at All Children's Hospital
501 6th Avenue South
Box 7380
St. Petersburg, FL 33701
Attention: Sue Papadopoulos

You will be contacted within 2 weeks of receipt of this application.