New Client Information Form

Date: _____

Child's First Name:_____Last Name:_____ Date of Birth:_____ Sex: M / F
Address: _____
City:_____ State:_____Zip:_____Home Phone:_____
Is your child adopted? Yes / No Age at adoption: _____

Guardian Name (1):_____
Address: _____
City:_____ State:_____Zip:_____Home Phone:_____
Cell:_____ Email:_____
May we add you to our client email list? ☐Yes ☐No

Guardian Name (2):_____
Address: _____
City:_____ State:_____Zip:_____Home Phone:_____
Cell:_____ Email:_____

Emergency Contact: _____ Relation to Patient:_____
Home Phone: _____ Cell Phone: _____

Referring Practitioner/Pediatrician:_____
Address:_____ City:_____ State:_____ Zip:_____
Phone Number:_____ Fax Number:_____

How did you hear about us?: ☐Doctor ☐Google ☐Mobile Website ☐Teacher/Therapist ☐Another Client Please share the name of the person who referred you so we can thank them:_____

What is your primary concern or reason for bringing your child for therapy?

_____
_____
_____

Specialists

Specialist Name:_____ Specialty: _____
Address:_____ City:_____ State:_____ Zip:_____
Phone Number:_____ Fax Number:_____
Next Appointment: _____

Specialist Name:_____ Specialty: _____
Address:_____ City:_____ State:_____ Zip:_____
Phone Number:_____ Fax Number:_____
Next Appointment: _____

Specialist Name:_____ Specialty: _____
Address:_____ City:_____ State:_____ Zip:_____
Phone Number:_____ Fax Number:_____
Next Appointment: _____

New Client Information Form

General Information

Child's Daycare/Preschool/School: _____ Grade: _____
Does your child receive services at home or school? _____

Circle services provided: OT PT Speech Special Instructor Hearing Vision Behavioral

Does your child's teacher have concerns about your child's development in the following areas?

Fine Motor Gross Motor Speech Learning Attention Behavior Social Skills

Siblings and ages: _____
Other important people your child may mention: _____
Pets: _____

What are your child's strengths? _____
What are your child's interests/favored activities? _____
_____

Are there any customs or religious beliefs that might affect your child's care? _____
_____

Birth History

Was your child FULL-TERM / PREMATURE; if premature, how many weeks? _____
Delivery: VAGINAL / FORCEPS / SUCTION / C-section
Were there any complications? _____
Was your child placed in the Newborn Intensive Care Unit? YES / NO If yes, for how long? _____
Please describe any other medical problems or complications at birth: _____
_____

Developmental History

Please indicate at what age your child achieved the following milestones. Use N/A for milestones your child has not achieved yet.

Can hold head up when on belly_____
Rolled belly to back _____
Rolled back to belly _____
Sat alone _____
Crawled _____
Pulled to stand _____
Stood Alone _____
Walked alone _____

Babbled _____
Said First Word _____
Drank from a cup _____
Used spoon _____
Dressed self _____
Toilet Trained _____

My child seems to be: RIGHTHANDED / LEFT HANDED / NO CLEAR PREFERENCE

Concerns or comments about development: _____
_____

New Client Information Form

Medical History

Does your child have a medical diagnosis? If so, what? _____

_____

Hospitalizations: YES / NO
If yes, please describe: _____

_____

_____

Surgeries: YES / NO

Type of surgery:	Date:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Behavioral/Psychological Evaluations: YES / NO
Results: _____

_____

Does your child take medications? YES / NO If so please list.

_____

_____

_____

_____

_____

Do you have any feeding or nutritional concerns regarding your child? YES / NO
Please describe: _____

Please circle if your child has any of the following:

Central line or port: YES / NO
Feeding tube: YES / NO
Tracheostomy YES / NO
Migraines / Headaches: YES / NO
If so, please describe: _____
What triggers the migraine?: _____

Seizures: YES / NO
If so, please describe: _____
What triggers the seizures?: _____
Latex Sensitivity: YES / NO
Allergies: YES / NO
Please list: _____

New Client Information Form

Medical History continued

Vision Problems: YES / NO
Wears Glasses: YES / NO
Hearing Difficulty: YES / NO
Hearing aids or FM: YES / NO
Broken Bones: YES / NO
What bones? _____ Date: _____
Bone: _____ Date: _____
Bone: _____ Date: _____

Does your child use a walker/wheelchair/braces?

_____

_____

Social Skills and Behavior:

Does your child make friends easily? YES / NO
Does your child have any fears we should know about (being up high, fast movement)? YES / NO
Please list:_____

Does your child have difficulty calming himself/herself when upset? YES / NO

Please circle any of the below that apply to your child:

Anxious	Avoids touch from others	Bangs Head
Bites	Cries often	Clumsy
Dislikes hair brushing	Dislikes tooth brushing	Dislikes playground equipment
Frequent Temper Tantrums	Mouths objects	Picky eater
Poor attention span	Rocks self	Seems to be on the “go”
Sensitive to light	Sensitive to sound	Throws things
Trouble following directions	Trouble with changes in routine	Weak muscles
Has trouble paying attention	Has trouble following directions with backround noise	
Refuses to wear certain clothes		

Please describe:_____

_____

Is there anything else we should know about your child or your family?_____

_____

_____

Revised Dec 26, 2013