Client Information Sheet

Client Full Name: _____ Date of Birth: ___/___/___

Age: ____ Gender: _____ Telephone: Home #: _____ Cell#: _____

Parent/ Guardian Name: _____

Parent/ Guardian Name: _____

Email:_____

Home Address: _____

Sibling's/Ages: _____

Primary Care Physician: _____ Phone #: _____

Others Living in the Home: _____

Languages Spoke in the Home: _____

WHO IS RESPONSIBLE FOR THE CLIENT'S BILLS?

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____

Date of Birth: ___/___/___ Employer:_____

Phone # of Employer: _____

Address of Employer: _____

WHOM MAY WE CONTACT IN THE EVENT OF AN EMERGENCY (OTHER THAN PARENT)?

Name: _____

Telephone #: _____

Relationship: _____

WHO CAN WE THANK FOR REFERRING YOU:

_____

BIRTH HISTORY

Pregnancy:

Age of Mother: _____ Length of Pregnancy: _____

General Health of Mother: _____

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Complications: _____

Medications taken during pregnancy: _____

Delivery:

Duration of Labor: _____ Type of Delivery: _____

Difficulties during delivery: _____

Birth weight: _____ Birth Length: _____ Intensive Care (NICU) needed? __ Yes__ No

Any health problems the first 2 weeks of life? _____

MEDICAL HISTORY

Hospitalizations: O Yes O No Describe: _____

High Fevers: O Yes O No Describe: _____

Ear Infections: O Yes O No Describe: _____

Hearing Problems: O Yes O No Describe: _____

Vision Problems: O Yes O No Describe: _____

Allergies: O Yes O No Describe: _____

Surgeries: O Yes O No Describe: _____

Seizure Disorder: O Yes O No Describe: _____

Colic: O Yes O No Describe: _____

Is your child presently under the care of any doctor other than your pediatrician? O Yes O No

Name of Doctor: _____

Reason: _____

Medications: _____

Current: _____

Previous: _____

MEDICAL PRECAUTIONS:

Are there any precautions the therapist should be aware of when working with your child?

_____

_____

_____

Developmental History

Motor milestones: At what age did your child:

Roll: _____ Sit: _____ Pull to stand: _____ Crawl: _____ Walk: _____Ride a tricycle: _____ Ride a bike: _____

Use writing utensil: _____ Cut with scissors: _____ Feed self: _____ Reach for objects: _____ Drink from cup: _____

Use a Straw: _____ Toilet Training: _____

Speech/Language milestones:

Did your child babble and coo during infancy? ____ When did your child say his/her first word? _____

When did your child begin to put words together? _____ Does your child speak clearly? O Yes O No

Do others understand your child? O Yes O No

Is your child's voice hoarse or husky? O Yes O No Describe:_____

Does your child Stutter? O Yes O No Describe:_____

Has your child's speech/language been evaluated prior? O Yes O No Where? _____ When? _____

Results? _____ Is your child self conscious about his/her speech? _____

Social History:

How does your child play with other children: please check all that apply:

o Cooperative o Leader o Aggressive o Picked on o Makes friends easily o Needs to be in control

o Shares well with others o Extremely shy

List any concerns you may have about your child's social skills: _____

Favorite toys/activities: _____

Behavior: Please check all that apply to your child:

o No specific problems o Easily frustrated o Difficult to discipline o Short attention span

o Plays well with others o Easily distracted o Self injurious behavior o Redirects with support

Educational History:

Please list schools attended (include day care and preschools):

Dates attended: Name/location/district:

_____

Is your child in a special education classroom and/or receiving special education services? _____

Please describe services: _____

Therapy History:

List any therapy your child has received (When, where, and duration treatment):

_____

_____

Is there any other important information that you feel may be helpful to your child's treatment?

_____

_____

What goals would you like your child to achieve through therapy? _____

_____

This information will be kept confidential and used solely for the purpose of providing the appropriate care to your child. Thank you.