TherapyWorks 4 Kids, LLC™ Patient Name _____

New Patient Information

Child's Legal Name: _____
(First) (MI) (Last)

D.O.B.____/_____/_____ Age _____ Female/Male Home# (_____)_____

Home Address:_____

City/State/Zip: _____

Parent Email address: _____

Parent/Guardian 1: _____Cell#/work#:(_____)_____

Parent/Guardian 2: _____Cell#/work#:(_____)_____

Who has legal custody of the child? _____

Emergency Contact Information: Please list who we may call in case of emergency AND who may pick up the child from appointments other than custodial parent or guardian.

Name _____ Ph # _____Relationship _____

Name _____ Ph # _____Relationship _____

Medical History:

Please list all your child's physicians/specialties:

Name:_____ Specialty_____

Name:_____ Specialty_____

Name:_____ Specialty_____

Name:_____ Specialty_____

What is your primary concern for having your child evaluated? _____

_____

_____

Does your child currently receive therapy services through any other program/location?

TherapyWorks 4 Kids, LLC™ Patient Name _____

Please list any medical diagnoses that your child has been given:

_____

_____

_____

Please list all your child's medications: _____

_____

_____

Pregnancy/Birth History:

Birth Weight:_____ Weeks gestation: _____

List any medical problems during first few weeks of life, including hospitalizations: _____

_____

_____

Developmental Milestones: (please list age at time of reaching milestone **without help**)

Rolling		Finger fed self	
Getting into sitting		Toilet trained	
Sitting alone		Dresses self	
Crawling		Eats with utensils	
First steps		Walk alone	
Spoke first word		Puts several words together	

Health:

Has your child:

Had his/her hearing checked? _____Yes _____No Date:_____ Results: _____

Had his/her vision checked? _____Yes _____No Date:_____ Results: _____

Had their immunizations? _____ Yes _____ No Are they up to date? _____ Yes _____ No

Please list any allergies: _____

TherapyWorks 4 Kids, LLC™

Patient Name _____

Other:

What are your child's interests?: _____

_____

Please list your goals for therapy (what you would like your child to achieve)**:**

_____

_____

Please list anything else you would like us to be aware of:

_____

_____

Please let us know how we may contact you regarding appointments and your child's therapy:

_____ Home phone/voicemail _____

_____ Cell phone/voicemail _____

_____Work phone/voicemail _____

_____ Email _____

How did you hear about us? _____

_____	_____	_____
Parent/Guardian Printed Name	Signature	Date