Patient Name ______________________

Child's Legal Name: FIRST________________________MI_______LAST_____________________________

DOB____/_____/________ Age ______________ Female/Male Home# (_____)___________________

Home Address:____

City/State/Zip: ____

Parent/Guardian1:________________________________DOB____/____/____ Cell# (_____)_____________

Parent/Guardian 2: _______________________________DOB____/____/____ Cell# (_____)____________

Who has legal custody of the child? ____

Who lives in the home of the child? (list below):

Name/Relationship to child/Age (if child): ____

Name/Relationship to child/Age (if child) ____

Emergency Contact Information: 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 ____________________

History:

What is the primary concern for having your child evaluated? ___________________________________

____

Does your child currently receive therapy services at any other location? Or at school? (please list)

____

List any medical diagnoses that your child has been given:

____

____

List all your child's medications: ____

____

Birth Weight:__________________ Weeks gestation: _______________

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

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

Patient Name ______________________________

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: ____

Family history:

Does anyone in your **family** have a history of the following:

	Circle:	**Describe difficulty:**	**Relationship to child:**
Communication difficulties?	YES/ NO		
Physical difficulties?	YES/ NO		
Learning disability?	YES/ NO		
Mental illness?	YES/ NO		

How may we contact you regarding information about your child?

____ Home phone/voicemail ____

____ Cell phone/voicemail ____

____ Email ____

How did you hear about us? ____

_________________________________ _________________________________ ____________________

Parent/Guardian Signature Print name Date

I, _________________________________ (print) hereby authorize TherapyWorks 4 Kids, to send me an appointment reminder via text or email and/or contact via phone call using the following information. *Reminders may contain patient or clinic information such as, but not limited to, patient first name and clinic location.*

Patient/Guardian Contact info (*please print clearly & legibly):*

Email ____

Cell phone ____

Parent/Guardian(print) ____

Signature ____ Date _______________