NEW CLIENT INFORMATION

Today's date:_______

LLC 4100 S Lindsay Rd., Suite 114, Gilbert, AZ 85297 Phone: 623-396-5467 Fax: 602-926-0258

Child's Name:____ M / F Child's Date of Birth: ________________

Parent(s)/Guardian(s) 1) _____________________________________ 2) ____

Address: ____ City:_______________________ Zip code:______________

Home Phone:__________________________________ Cell 1:___________________________ Cell 2:_________________________

Father's Employer:____ Work Phone: _________________________

Mother's Employer:____Work Phone: _________________________

*Email Address:____ *Main contact to send evaluation report and other correspondence

Emergency Contact (besides parents): ____ Phone:_____________________

Child Lives with (circle): Both parents Mom Dad other: ______________________________

Siblings (name/age): ____

Child's School: ____ Grade: _________ 504/IEP (Circle): Y / N

Primary Physician:____Phone: ____________________ Fax:_____________________

Physician's Address:____ Order/Script Provided: Y / N

Does your child see any other specialists? If yes, please list: ____

Please list current concerns and reason for referral: ____

____

Goals for Treatment (what would I like my child to be able to do by end of therapy): ____________________________________

____

MEDICAL HISTORY:

Patient Diagnosis:___________________________________ Previous Hospitalizations (Date, type, length):_________________

____

Orthotics/Braces Used (Type, length of use): ____

Current Medications (Name, indication, frequency): ____

Does your child have a history of (please circle):

Seizures: Y / N **Head Injury**: Y / N **Asthma**: Y / N **Vision Loss/Correction**: Y / N **Hearing loss**: Y / N

If you answered yes, please explain:____

____

ALLERGIES:____ **Epi-Pen Needed**: Y / N Are there any special precautions or limitations that pertain to therapy restrictions or contraindications? (e.g. Physician precautions) ____

____

DEVELOPMENTAL HISTORY:

Pregnancy/Birth (complications before during and after birth): ____

____

Full-Term Weeks: _______ Pre-Term/Gestational Weeks _________ Delivery (please circle): Vaginal Cesarean

At what age did your child first.....

Roll Over:_____________ Sit Alone:______________ Crawl:_____________ Stand:______________ Walk Alone:_____________

Eat Baby food:____________ Say first words:_______________ Eat Solid Foods: _____________ Drink from Cup: __________

Dress: _____________ Feed Self: _________ Tie Shoes: __________ Ride Bike: ___________ Dominant Hand: R / L or both

Is there anything else the Therapist should know about your child? (e.g. behaviors, sensitivities, fears):________________________

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How did you hear about WTG? FB / Google Search / Website / Pediatrician / Friend __________________________________