**Unbridled Occupational Therapy, LLC**

***Client Information Sheet***

***PLEASE PRINT CLEARLY***

Client Name: Date of Birth:   
Sex: Race: Ethnicity: Height: Weight:   
Parent or Legal Guardian(s):   
Address:   
   
Phone Home: Cell: Other: Email(s):   
How did you hear about us?   
Type of payment (Cash/Check ) :   
  
Diagnosis/ Medical History( if applicable )

Alerts/ Precautions:

Other therapies:

Referring therapist, Dr. name/phone/email:

Primary Care Physician: Practice name, Doctor's name, address, office and fax number:

Concerns: (information regarding this client that may assist in providing best care):

1-Social/Emotional (behavior, self-regulation, peer interaction) Y N 2-Cognition (attention, problem-solving) Y N 3-Coordination (gross or fine motor) Y N 4-Sensory Integration Y N

5-Strength/Balance/ Endurance/Tone Y N 6-ADLs, Self-care Y N 7-Stress Y N

8-communication Y N 9- Mindfulness Y N 10 -Relationships Y N

11-Team building Y N

Please add any specific goals: