Client Demographics:

|  |
| --- |
| Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_             \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_                                    First                                                           Last MI  Age:                             Date of Birth: / / |
| |  |  | | --- | --- | | Current Diagnosis: | Date of Diagnosis: | | Diagnosed By: | Age at Diagnosis: | |

Reason for Referral (Brief Summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Availability: Times and Days

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
|  |  |  |  |  |  |  |

Parents and/or Guardians:

|  |  |
| --- | --- |
| Mothers Name: | Fathers Name: |
| Home Number: | Home Number: |
| Mobile Number: | Mobile Number: |
| Work Number: | Work Number: |
| Email Address: | Email Address: |

1. Are parents married\_\_\_\_\_\_\_\_\_\_ Divorced\_\_\_\_\_\_\_\_\_ Separated\_\_\_\_\_\_\_\_\_\_\_

If divorced, who has custody of minor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What days?

Please list any step parents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List any others living in the home or are involved with Child:

|  |  |  |
| --- | --- | --- |
| **Name** | **Age** | **Relationship** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**School/Childcare Center:**

|  |
| --- |
| Name of School/ Center: |
| Principal/Contact Person: |
| Teachers Name: |
| Phone Contact: |
| Email: |
| Address: |

**Primary Insurance:**

|  |
| --- |
| Subscribers Name: |
| Carrier: |
| Group Number: |
| Phone Number: |
| ID # |
| Fax# |

**Primary Care Provider**

|  |  |  |
| --- | --- | --- |
| Name: | | Phone: |
| Address: | City: | |
| State/Zip Code: | Contact #: | |

Current Medical Conditions:

|  |  |
| --- | --- |
| Please list any medical diagnosis: | Cerebral Palsy\_\_  Autism/PDD\_\_\_ Hyperactivity\_\_  ADHD\_\_\_\_ ODD (noncompliance)\_\_\_ |
| Please list any current allergies that your child may have: |  |
| Please list any special nutritional needs: |  |
| Are immunizations up to date? |  |

**\*A copy of an up to date Physical and Psychological Evaluation/Diagnosis is needed to gain approval for initial assessment.**

Parent/Guardian Signature X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_

Print Name X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_