Motivated Kids therapy

General Information

Childs Name: _____ Date: _____

Nickname:_____ Date of Birth: _____ Gender: ☐Male ☐Female

Address: _____ Home Phone: (___) _____

_____ Other Phone: (___) _____

Child's Primary Language: _____ Childs Secondary Language: _____

Reason for Referral: _____

_____

Referred by: _____

_____

Parent's Primary Concern: _____

_____

Guardian's Name: _____ Guardian's Name: _____

Address (if different from above): _____ Address (if different from above): _____

_____ _____

_____ _____

Home Phone: (___) _____ Home Phone: (___) _____

Email Address: _____ Email Address: _____

Occupation: _____ Occupation: _____

Employer's Name: _____ Employer's Name: _____

Employer Address: _____ Employer Address: _____

_____ _____

Phone: (___)_____ Phone: (___)_____

Insurance Information

Subscriber's Last Name: _____ First Name: _____

Subscriber's ID#: _____ Subscriber's Date of Birth: _____

Primary Insurance Company's Name: _____

Insurance Company Phone: _____ Coverage Effective Date: _____

Group Number: _____ Policy Number: _____

Client Relationship to Subscriber: _____

Secondary Insurance Subscriber's Name (if different from above): _____

Subscriber's ID#: _____ Subscriber's Date of Birth: _____

Primary Insurance Company's Name: _____

Insurance Company Phone: _____ Coverage Effective Date: _____

Group Number: _____ Policy Number: _____

Medical Information

Primary Physician: _____
Phone: _____
Fax: _____
Address: _____
_____

Other Physician: _____
Phone: _____
Fax: _____
Address: _____
_____

Other Physician: _____
Phone: _____
Address: _____
Fax: _____

Other Physician: _____
Phone: _____
Address: _____
Fax: _____

Medical Diagnosis: _____
_____

Medications (purpose & frequency): _____
_____

Any Assistive Devices (glasses, wheelchair, communication devices, orthotics): _____
_____

Any Medical Precautions or Allergies: _____
_____

Newborn Hearing Screening (Pass or failed. If failed, please explain, and indicate right or left ear): _____
_____

Other Hearing Concerns: _____

Hospitalizations (Date, reason, and length of stay): _____

Surgeries (Date and Procedure): _____

Pregnancy and Birth History – Did the child's mother have any illnesses or complications during pregnancy or delivery?
Please explain: _____
_____

Was the child born premature? Yes_____ No_____ Weeks of Gestation _____

Did child require time in NICU? _____ Length of stay? _____

Development History – Please indicate at what age each major milestone was reached:

Sitting by self: _____ Crawling: _____ Walking: _____ First word: _____ Two words together: _____

Feeding History – Does the child have any feeding issues? (If so, please explain present and past issues): _____
_____

Therapy History (received or currenting receiving therapy somewhere else? Please explain when and where): _____
_____

School History – School name and teacher: _____

Grade: _____ Hand preference: Left _____ Right _____

Does the child receive special instructions or have an established IEP? _____