



CLIENT INFORMATION FORM

Child's Name:

Parents's Name:

DOB:

Address:

E-Mail

Phone

Home:

Cell:

Work:

Insurance Information:

Insurance Company:

Policy Number:

Primary Insurers Name:

DOB:

Employer:

Copay amount:

Additional Information

Child's interests:

Allergies:

BACKGROUND INFORMATION

Concerns:

Birth History

Medical History (any illnesses, hospitalizations or diagnosis)

Developmental History:
Motor milestones

Speech and language:
First words
Two word combinations
Sentences

Speech sounds:

Hearing Status:

Did your child pass the newborn hearing screen?
Has your child had formal hearing assessment with an audiologist?
Date: Results:

Education:

Previous Evaluation and Results:

Support Services:

Speech:	Frequency
Physical Therapy:	Frequency

Occupational Therapy	Frequency
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Other: