NEW CLIENT INFORMATION

Today's date:_____

Way to Grow Pediatric Therapy 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):_____

_____

_____

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