NEW CLIENT INFORMATION

Todays date:_____

2715 S. Alma School Rd., Suite #3, Chandler, AZ 85286 Phone: 480-508-5252 Fax:480-454-3737 Email:office@waytogrowaz.com

Child's Name:_____ M / F 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:_____ Address:_____ Order/Script Provided: Y / N

Does your child see any other specialists? If yes, please list:_____

_____

Current Concerns and reason for referral: _____

_____

Goals for Treatment:_____

_____

BIRTH AND DEVELOPMENTAL HISTORY

Neonatal weight _____ length _____ **Delivery** (please circle): Vaginal Cesarean Emergency Y / N

Pre-Term/Gestational Weeks _____ Length of hospital stay _____

Complications (please circle all that apply): Gestational Diabetes Pre-Eclampsia Jaundice Seizures
Congenital Abnormalities Respiratory Distress Drug Withdrawal C-Pap or Intubation NICU Y / N _____

Went home on oxygen Y / N How long? _____

At what age did your child first.....

Roll Over:_____ Sit Alone:_____ Crawl:_____ Pull to Stand:_____ Stand:_____
Walk Alone:_____ Say first words:_____ Eat Baby food:_____ Eat solid foods:_____ Drink from cup:_____ Dress self:_____ Feed self:_____ Tie shoes:_____

Ride bike:_____ Dominant Hand: R / L or both

MEDICAL HISTORY

Patient Diagnosis:_____ Current Medications (Name and indication): _____

Previous Hospitalizations (Date, type, length) _____

_____

Orthotics/Braces Used (Type, length of use): _____

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 Aides: 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 (e.g. Physician precautions)_____

_____

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 / Yelp / Pediatrician / Friend / Other _____