CAROLINA THERAPY CONNECTION

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Patient Information Form

Please complete all information on this form

Client's Full Name: _____Date of Birth: _____

Demographics

Mother's Name:	Address:	Employer:
Cell phone #:	Home phone #:	Work #:
Mother's date of birth:	Mother's Social Security # (required for billing purposes):	
Father's Name:	Address:	Employer:
Cell phone #:	Home phone #:	Work #:
Father's date of birth:	Father's Social Security # (required for billing purposes):	
Emergency contact name and relationship:		Phone #:
Name of current school:		Grade:

Medical Information

Primary Care Physician:	Secondary Physician (any other professional medical reports should be sent to):	
Diagnosis:		Date Diagnosed:
Present Medications:		
Birth Weight: _____lbs. _____oz.	Complications with delivery:	Weeks Gestation:
Surgeries (include date):		

Does your child have any adaptive/medical equipment: □ no □yes (please explain):
Does your child follow any special diet or have any feeding issues: □ no □yes (please explain):
Does your child have any allergies: □ no □yes (please list):
Other medical concerns/precautions:
Describe any family history of developmental or learning concerns:
Is your child currently receiving other therapy services or received in the past (where/when): □ OT _____ Date _____ □ PT_____ Date _____ □ ST_____ Date _____ □ Counseling/Psych _____ Date _____

Therapy Goals

Please briefly describe your concerns and desired outcomes for your child

Occupational Therapy:
Physical Therapy:
Speech Therapy:

Please enclose any other important evaluation/medical reports you may have