Child's Name:	Sex:	DOB:	Age:

Parent(s)/Guardian Name(s):

Address:

City:	State:	Zip Code:

Email:

Home Phone:	Cell Phone:

School/Daycare:	Grade Level:	Days/week:

Other people who live in the home:

Languages spoken in the home:	Primary language child understands:

Medical Diagnosis:	Major illnesses/surgeries (please provide dates):

Current Medications:	Allergies/dietary restrictions:

Primary Care Doctor:

Please describe the primary concerns that brought you here today:

Does your child see any other specialists at this time? (please list)

How many weeks gestation was child born? (40 weeks is typical) ________ weeks ● C-section ● Vaginal Delivery	Pregnancy/Delivery Complications:

Does your child exhibit aggressive or destructive behaviors to self or others? (please describe)

What are your child's favorite play interests/hobbies?

What would you like to see your child doing in 6 months that he/she is not doing now? (your goals for therapy)

Parent/Guardian Signature:___________________________________

Date: _________________