

## CLIENT INFORMATION FORM

### Family Details

Child's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City / Town: \_\_\_\_\_ County: \_\_\_\_\_ Post Code: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Home Fax Number: \_\_\_\_\_

Parent / Guardian: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Parent / Guardian: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Sibling / Age: \_\_\_\_\_ Sibling / Age: \_\_\_\_\_

Sibling / Age: \_\_\_\_\_ Sibling / Age: \_\_\_\_\_

Sibling / Age: \_\_\_\_\_ Sibling / Age: \_\_\_\_\_

### Emergency Contact Information

In Case of Emergency: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ Post Code: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

### Referral Information

How did you hear of us? \_\_\_\_\_

**Medical Information**

Diagnosis: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Diagnosing Physician: \_\_\_\_\_ Agency / Clinic: \_\_\_\_\_

Family GP: \_\_\_\_\_ Phone: \_\_\_\_\_

Paediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Psychologist: \_\_\_\_\_ Phone: \_\_\_\_\_

Neurologist: \_\_\_\_\_ Phone: \_\_\_\_\_

Additional Diagnosis: \_\_\_\_\_

Medical / Health Issues: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

**Developmental Milestones**

Sat at Age: \_\_\_\_\_ Crawled at Age: \_\_\_\_\_ Walked at Age: \_\_\_\_\_

Babbled at Age: \_\_\_\_\_ Spoke at Age: \_\_\_\_\_ Lost Words: \_\_\_\_\_

Current Communication: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Communication System Used (circle one):      Gesture      Sign      PECS      Speech

Does your child point? \_\_\_\_\_ Play Peek a Boo? \_\_\_\_\_ Wave Hello or Goodbye? \_\_\_\_\_

Does your child have difficulty with change in routine? \_\_\_\_\_

Explain: \_\_\_\_\_

Does your child have any "inappropriate" or "stereotypical" behaviours? \_\_\_\_\_

Explain: \_\_\_\_\_

Does your child have a limited diet? \_\_\_\_\_

Explain: \_\_\_\_\_

Is your child toilet trained? \_\_\_\_\_

Explain: \_\_\_\_\_

**Treatment History**

Include Pre-School, School, Therapies (OT / PT / SP), Previous Consultants, Alternative Treatments

Provider / Agency: \_\_\_\_\_

Service Provided: \_\_\_\_\_

Date Began: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax / Email: \_\_\_\_\_

Provider / Agency: \_\_\_\_\_

Service Provided: \_\_\_\_\_

Date Began: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Address: \_\_\_\_\_

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Service Provided: \_\_\_\_\_

Date Began: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax / Email: \_\_\_\_\_

**For Clinic Use Only**

Date Received: \_\_\_\_\_

- Diagnostic Report Received
- Psychological Assessment Report Received
- Additional Reports Received