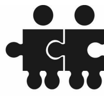

PEDIATRIC THERAPIES at COOL SPRINGS

1880 General George Patton Drive
Suite 202B
Phone: 615-377-1623 Franklin, TN 37067 Fax: 615-377-1625

NEW CLIENT FORM

Today's Date: ______________________

Child's Name: ____ Birth Date: ________________________
Person Completing Form: _______________________________ Relationship to Child: _______________
Pediatrician: ______________________________ Referring Physician: _____________________________

Prioritize your top 3 concerns you want to be sure we address in this evaluation and/or therapy:
1. ____
2. ____
3. ____

Current diagnoses: ____
____

Family History:
Lives with both parents: Yes _____ No _____ If no, describe: __________________________________
____

Siblings (names, ages, any history of delays): ____
____

Birth History:
Is this child: Biological child _____ Adopted child _____
Please indicate: Length of pregnancy: __________ Birth weight: __________
Notable circumstances during pregnancy, labor, delivery, and/or following birth: ___________________
____

Medical History:
Please circle any of the following illnesses that are common conditions in your child or which your child has acquired. List approximate ages in the space provided.

Allergies _______ Asthma _______ Chicken Pox _______
Colds _______ Croup _______ Ear Infections _______
Headaches _______ High Fever _______ Measles _______
Pneumonia _______ Seizures _______ Sinusitis _______
Tonsillitis/Adenoids _______ Other ____

Please indicate your child's vaccination schedule:
Typical Schedule: _____ Alternative/Extended: _____ Not vaccinated: _____
Are there specific vaccinations your child will not be receiving (please list): ________________________
____

Has your child had a vision test/screening? Yes _____ No _____ Date: _______________
Results: ____

Has your child had a hearing test/screening? Yes _____ No _____ Date: _______________
Results: ____

Significant illnesses: ____
____

Specialists/Physicians seen (include dates, names, specialty): __________________________________
____
____

Special Tests (X-rays, MRIs, etc.) including dates: ____
____
____

Hospitalizations/Surgeries including dates: ____
____
____

Precautions: ____
____

Medications your child is taking and for what condition: _______________________________________
____
____

Developmental History:
Please indicate at what age your child achieved the following developmental milestones:
Sitting: ________ Crawling: ________ Standing: ________
Walking: ________ Babbling: ________ Single words: ________
Combining words: ________ Toilet training: ________

Describe general coordination: ____
____

Are there currently or have there been any feeding problems (i.e. sucking, swallowing, drooling, chewing, extreme picky eating, etc.)? Please explain: ____
____
____

Describe your child's current vocabulary: ____
____

How many words is he/she using?
1000's_____ 100s_____ 50–100_____ 25–50_____ 10-25_____ 10 or less_____ none_____

If non-verbal, how does he/she communicate? ____
____

Describe social language abilities: ____
____

Educational History:
School: ____ Grade: __________________
Please indicate your child's school schedule (i.e. days, times, etc.): ______________________________
____

List your child's teacher or other educational contact person and phone number if appropriate:
____

Describe your child's school performance: ____
____
____

What if any special services does your child receive at school? ____________________________________
____
____

Previous Assessments and Therapies:
Please list any other evaluations, **including dates** that your child has undergone or has pending (i.e. OT, PT, Speech and Language, Psychoeducational, etc.). List contact names and phone numbers.
OT: ____
PT: ____
SLT: ____
Other: ____
____

Please list any developmental therapies or interventions your child has participated in or is currently participating in (i.e. OT, PT, SLT, Music Therapy, counseling, etc.). Include dates: ____________________
____
____
____
____

Social and Other Information:

Interests/hobbies: ____
____

Describe peer relations: ____
____
____

Describe your child's most concerning/challenging behaviors: ___________________________________
____
____

My child's fears are: ____
____

What works to motivate or reward your child? ____
____

What other information would you like for us to know about your child? __________________________
____
____
____