Geneva Pediatric Therapy Center

Child's
Name:_____DOB:_____

Parent(s)/Guardian Name:_____

Home Address:_____

City:_____ State:_____ Zip: _____
Mailing Address: _____
(if different from above)
E-mail Address:_____

Home Phone:_____ Mother Cell: _____ Father Cell:_____

Father's Employer: _____ Work Phone: _____
Mother's Employer: _____ Work Phone: _____
Names and ages of family members living at home:
_____
Name of child's preschool: _____
Days and times of attendance: _____

Primary Insurance: _____If Tri-Care, Active or Retired? _____ Policy #_____
Insurance Phone Number: _____
Subscriber Name: _____ DOB: _____ SS#_____
Relationship to child: _____

Secondary Insurance: _____ Policy # _____
Insurance Phone Number: _____
Subscriber Name: _____ DOB: _____ SS#_____
Relationship to child: _____

I hereby grant permission for this facility to release my child to the following individuals in my absence:
Name: _____ Relationship:_____ Phone Number:_____
Name: _____ Relationship:_____ Phone Number:_____
Name: _____ Relationship:_____ Phone Number:_____

I hereby grant permission for this facility to contact the following medical personnel to obtain emergency care if warranted.
Primary Care Physician: _____ Referring Physician:_____
Address: _____ Phone: _____
Dentist: _____ Phone: _____
Hospital Preference: _____
Parent/ Guardian Signature:_____ Date: _____

Please describe your child's activity level:

_____

_____

Does your child exhibit and of the following behaviors? If so, describe

Perseverative/Repetitive _____

_____

Self Injurious _____

_____

What methods of discipline do you employ with your child at home? _____

_____

Does your child have any aversions or fears? _____

_____

What items or activities are reinforcing for your child? _____

_____

Previous Therapy/Treatment

Has your child been enrolled in therapy before?

Speech	Yes	No
Occupational	Yes	No
Physical	Yes	No

Comments about previous therapy/treatment: _____

_____

_____ _____

Name of person completing this form

Relationship to child

Geneva Pediatric Therapy Center
Medical History

Child's Name: _____ DOB:_____

Medical History

Child's birth weight: _____

Were there any problems during pregnancy or difficulties at birth?	Yes	No
Was your child born before the due date?	Yes	No
Has your child been hospitalized at any time?	Yes	No
Are there any diagnosed mental, physical, or emotional disabilities?	Yes	No
Does your child have any food allergies?	Yes	No
Does your child have any drug allergies?	Yes	No
Does your child have any significant health problems?	Yes	No

If you answered "yes" to any of the above, please explain:

_____

_____

Please list any medications you child is currently taking:

_____

Has your child has his/her vision checked?	Yes	No	Results: _____
Has your child ever had feeding difficulties?	Yes	No	

If "yes", please explain: _____

Hearing Status

Does your child talk in a very loud voice?	Yes	No
Does your child turn up the volume on the radio and TV?	Yes	No
Does your child hear you if his/her back is turned?	Yes	No
Does your child hear you if you talk to him/her from the other room?	Yes	No
Does your child have a history of ear infections?	Yes	No
How many? _____ Most recent: _____		
Has your child had a hearing test?	Yes	No
Date of most recent test:_____ Results: _____		