Add Therapy Center

Client History Form

General Information

Child's Full Name: _____

DOB: _____

Parent or Caretaker's Full Name: _____

Address: _____

City: _____ State: _____

Zip: _____

Is this address the same as your billing address? ☐ Yes ☐ No

If no please provide both your billing address: _____

_____

Who lives in the home with you? _____

Spiritual or Cultural considerations you want to share that may impact therapeutic decisions?

_____

Relationship to Patient: _____ Primary Phone: _____

Alternate Phone: _____

Email: _____

Full Custody_____ Other_____ if other, please provide a copy of the custody agreement

***if partial or joint custody, both parties will need to consent to treatment**

Alternate Email and Relationship to Patient:

_____

Language(s) spoken at home: _____

How did you hear about Add Therapy Center? _____

Emergency Contact Information

Add Therapy Center

Emergency Contact Name 1:

_____

Relationship to Patient: _____Phone:

_____

Emergency Contact Name 2:

_____

Relationship to Patient: _____Phone:

_____

Present Medical Information

Describe present concern related to appointment:

_____

_____

_____

Have any previous therapies or approaches been attempted? ☐ Yes ☐ No

If yes please describe:

_____

Has there been any significant medical or behavioral changes in the past 6 months? ☐ Yes ☐ No

If yes, what has changed?

_____

Please list any allergies:

_____

What is your child's current health? ☐ Good ☐ Fair ☐ Poor

Is your child taking any medications? ☐ Yes ☐ No If yes what?

_____

Does your child have any other medical diagnosis or concerns?

_____

Does your child have any adaptive or medical equipment?

_____

Indicate any illnesses, accidents, hospitalizations (include age/treatment):

_____

_____

Does your child have problems hearing? ☐ Yes ☐ No

If yes, please explain:

_____

Has your child experienced any ear infections? ☐ Yes ☐ No

Approximately how often? Rarely Occasionally Often

Has your child had middle ear tubes inserted? ☐ Yes ☐ No

If yes, when?

_____

Has your child's hearing ever been tested? ☐ Yes ☐ No

Results:

_____

Did your child have his/her adenoids or tonsils removed? ☐ Yes ☐ No

If yes, when?

_____

Does your child snore? ☐ Yes ☐ No

Does your child wear corrective lenses (glasses, contacts)? ☐ Yes ☐ No

If yes, at what age did your child begin to wear them?

_____

Therapy Goals

Please describe your goals for therapy. What do you hope to accomplish?

_____

Are you in need of any additional supports besides what you are being seen for today? ☐ Yes ☐ No

If yes, please describe:

_____

Birth History

Was pregnancy full term? ☐ Yes ☐ No

Was there anything remarkable about the mother's health during pregnancy or delivery? ☐ Yes ☐ No

If yes, please explain:

_____

Type of Delivery: ☐ Vaginal ☐ Caesarian ☐ Breech ☐ Suction ☐ Forceps

Was there any type of diagnosis or medical concern about the baby after birth? ☐ Yes ☐ No

If yes, please explain:

_____

Please describe any family history of developmental or learning problems:

_____

_____

Education/Therapy Information

Is your child enrolled in any type of childcare facility, preschool program, play group, developmental program, public school or private school? ☐ Yes ☐ No

Name of School/Facility: _____

How long have they attended? _____

Hours enrolled per week: _____ Current Grade Level: _____

Has your child ever had a school based evaluation? ☐ Yes ☐ No

Please briefly describe the results:

_____

_____

Does your child have an IEP? ☐ Yes ☐ No

What type of services do they receive?

_____

Please provide a copy of the IEP and Evaluation to Add Therapy Center.

Does your child receive speech/occupational/physical/counseling therapy at this time? ☐ Yes ☐ No

Speech Therapy	_____x/week
Occupational Therapy	_____x/week
Physical Therapy	_____x/week
Counseling	_____x/week

Where are these services provided?

_____