

HANDPRINTS & FOOTSTEPS

Patient History

Name of Child: _____ Date: _____

Date of Birth: _____

Parent/Guardian: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone (Father): _____

Cell Phone: _____ Work Phone (Mother): _____

Emergency Contact (other than parents) Name: _____ Number: _____

Is it okay to leave a message at these phone #'s? Yes ___ No ___ If no, please specify: _____

Diagnosis: _____

Allergies: _____

Other Medical Conditions/Diagnoses: _____

Referred By: _____

Parent Concerns: _____

Current/Previous OT/PT/SLP Program: _____

Primary Care Physician: _____

Other Physicians: _____

(Orthoped, Neurologist, _____

Ophthalmologist, etc.) _____

Medications: _____

Previous Surgeries: _____

Orthotics/Equipment: _____

Please fill out page two

Significant Birth History: _____

Method of Payment: _____

I understand that I am responsible for any portion of payment not covered by insurance or other agency, and agree to pay this amount at the time of service.

Signature: _____ Date: _____

I give consent for my child to undergo speech, occupational therapy, and/or physical therapy evaluations and participate in treatment outlined in therapist's plan of care.

Signature: _____ Date: _____

I give consent for students and/or volunteers to observe and/or participate in the treatment of my child.

Signature: _____ Date: _____