Client Information Form

Pediatric Clients

Name		DOB
Mother’s Name		
Address		
Occupation of Mother		
Phone Number	Email	
Father’s Name		
Address (if different from above)		
Occupation of Father		
Phone Number	Email	
Does your child have siblings? If so, what are the ages of the siblings? How many siblings live in the home?		

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Child's Grade Level:
Name of School:
Teacher's Name:
Child's Primary Language
List All Languages Spoken in the Home?
Does your child enjoy school? If you no longer attend, please indicate your attitude toward school when enrolled.
Does your child have an IEP? Does your child have a 504 Plan?
Academic Information (Please include a brief description of your child's academic performance)
Concerns (Please list all areas of concern. i.e. academic, behavioral, communication, motor development, social/emotional, etc)

(Pediatric Clients)

Please list and describe any delays in early development?
At what age did your child begin crawling, walking and talking?
Were there any prenatal, birth or postnatal complications?
Were there any complications or illnesses in childhood? (i.e. seizures, etc)
Name, phone number and address of peditrician: