Atlanta Children's Therapy Associates, Inc.

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Patient Info

Patient Name		**DOB**		**Sex**	
Address					
City		**State**		**Zip Code**	

Family and Household Information

Parent/Guardian Name:		**Parent/Guardian Name:**	
Phone Number:		**Phone Number:**	
Email:		**Email:**	
Number of Siblings		**Ages of Siblings**	
Languages Spoken in Home			

Please explain the concerns you have about your child (please include when this was first noticed)?	
Is your child currently receiving therapy services or have they received them in the past (Occupational, Physical, Speech, Feeding, etc.)? Please explain.	

Medical Information

Diagnosis	
Diagnosed by	

Pediatrician Information

Pediatrician Name	
Name of Practice	
Address	
Phone Number	

Other Physicians and Specialists Who Provide Care To This Child:

Name	Practice	Address	Phone

Developmental Milestones

Behavior	Age	Comments
Sat up independently		
Crawled		
Walked alone		
Spoke first word		
Put several words together		
Dressed self		
Finger fed self		

Ate with utensils		
Became toilet trained		

Medical History

At how many weeks was your child born?		**Birth Weight**	
How long after birth was your child discharged?			
Were there any complications during the pregnancy, delivery, or immediately afterwards?			
Has your child had their hearing checked in the past year?		**Date?**	
Has your child had their vision checked in the past year?		**Date?**	

Medical History Continued

	Yes	**No**	**If yes, please explain**
History of ear problems?			
History of allergies, tonsillitis, or asthma			

Are there any diagnosed medical, physical or emotional problems?			
Serious illnesses, injuries, or hospitalizations?			
Allergies?			

Medications

Name	Dosage	Frequency	Reason for Medication

Medical Procedure History

Procedure	Date

General

What are your child's interest (favorite toys, activities, songs, etc.)?	
What are your goals for therapy?	