FUNCTIONAL KIDS CLINIC

Today's Date_____ Your Initials_____

OT_____ ST_____ PT_____

Eval Date_____

OT _____ ST_____ PT_____

Eval Date_____

Patient Registration Form

Patient's First Name: _____ MI: _____ Last Name:_____

Address: _____ City, Zip: _____

DOB: _____ Gender: □ Male □ Female

Parent/Guardian:_____ Relationship to Patient:_____

Phone_____ 2nd Phone_____ Email Address: _____

2nd Parent/Guardian: _____Relationship to Patient: _____

Phone_____ 2nd Phone_____ Email Address: _____

Primary Language: _____ Interpreter Required? □ Yes □ No

Diagnosis: _____ Allergies/Food Allergies: _____

Main Concerns: □ Articulation □ Language □ Oral-Motor □ Feeding □ Social □ Motor Skill
□ Sensory Processing □ Hyper/Hyposensitivity □ Emotional/ Behavioral □ Aggressive Behaviors □ Hearing
□ Alternative Communication Devices□ Other: _____

_____

_____

Patient's Physician: _____ Clinic Name: _____

Insurance Name: _____

Policy Holder: _____ DOB: _____

ID #: _____ Group #: _____

Secondary Insurance Name:_____

Policy Holder: _____ DOB: _____

ID #: _____ Group #: _____

Previous therapy services? □ Yes □ No Type/Where: _____

Does the child have a school IEP?_____

How did you hear about us? □ Physician □ Employer □ Case Manager □ School □ Hospital □ Other: _____

What is your availability for regular appointments? _____

Text reminders? Y_____N_____

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