JUMPSTART THERAPY

Helping Kids Be Kids

Client Information

Child's Name:_____Date of Birth:_____

Parent/Guardian Name(s):_____

Address:_____

Telephone Numbers: (Home)_____(Cell)_____

(Work)_____Email_____

Pediatrician:_____Pediatrician's Phone Number:_____

Has your child ever been given a medical diagnosis? If yes, what diagnosis?_____

_____

Does your child have any allergies?_____

Is your child on any medications? If yes, please list._____

Other Professionals Working With Child:

Name(s)	Phone Number(s)
_____	_____
_____	_____

Child's School:_____Grade:_____

What concerns do you have about your child?_____

_____

_____

What do you see as your child's assets and strengths?_____

_____

_____

Are there any special circumstances or precautions that the therapist should be aware of?_____

_____

What do you hope to gain from this OT evaluation and/or treatment intervention?_____

_____

_____

_____

How were you referred here?_____