

CLIENT REGISTRATION

Name of Client: _____ Date of Birth: _____
Address: _____

Mother's Name: _____ Father's Name: _____
Address if different: _____ Email Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Caregiver's Name: _____ Contact Phone: _____

In case of medical emergency, contact:

Relationship: _____ Phone: _____

Relationship: _____ Phone: _____

Relationship: _____ Phone: _____

Preferred medical facility: _____ Health Insurance Company: _____
Policy Holder's Name: _____ Policy #: _____

Please list all allergies (food, etc.) Please include any diet restrictions.

Primary Concerns and Goals for therapy:

School Placement _____ Phone No.: _____
Teacher's Name _____ Phone No.: _____
School Schedule: _____

PT _____ Facility: _____ Phone No.: _____
Frequency & Duration: _____

OT _____ Facility: _____ Phone No.: _____
Frequency & Duration: _____

SLP _____ Facility: _____ Phone No.: _____
Frequency & Duration: _____

Home Program Information: If applicable

Home Program Coordinator: _____ Phone No.: _____
Home Program Tutor: _____ Phone No.: _____

Phone No.: _____

Phone No.: _____

Total Hours Weekly: _____

I am interested in the following treatment services for my child:

_____ Speech and language therapy	_____ Articulation or Language Therapy
_____ Feeding Therapy	_____ Hippotherapy
_____ Oral Motor Therapy	_____ Fast Forward
_____ Home Program Coordination	_____ Links to Language
_____ Home Program Consultation	_____ Speech Motor (PROMPT)
_____ Applied Behavior Analysis	_____ Other: Please specify _____