Wee Speak Therapy & Learning Center

Patient History

Date: _____

Name of Child: _____ Age: _____

Date of Birth: _____

Parent/Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Work Phone (Father):_____

Cell Phone: _____Work Phone (Mother):_____

Emergency Contact (other than parents):_____

Emergency Contact Phone Number: _____

Is it ok to leave a message at these numbers? Yes_____ No _____ If no, please specify:

_____

Diagnosis: _____

Allergies: _____

Other Medical Conditions/Diagnoses: _____

Referred By: _____

Parent Concerns: _____

_____

_____

Current/Previous OT/PT/SLP Program: _____

_____

_____

Primary Care Physician: _____

Wee Speak Therapy & Learning Center

Patient History Continued

Other Physicians: _____

(Orthopod, Neurologist, Ophthalmologist, etc)

Medications: _____

Previous Surgeries: _____

Orthotics/Equipment: _____

Significant Birth History:

_____

_____

Parent/Guardian Signature: _____ Date: _____

I give consent for my child to undergo speech, occupational therapy, and/or physical therapy evaluations and participate in treatment outlined in the therapist's plan of care.

Parent/Guardian Signature: _____ Date: _____

I give consent for students and/or volunteers to observe and/or participate in the treatment of my child.

Parent/Guardian Signature: _____ Date: _____