Client Information Form

Big Gym Therapy
Less like work. More like fun.

General Information

Child's name: _____ Birthdate: _____ Gender: ☐ M ☐ F

☐ Parent(s) ☐ Guardian(s) ☐ Foster Parent(s) Names: _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Telephone: ( ) _____ Cell Phone: ( ) _____

Email address: _____

Referring Physician: _____ Practice: _____ Phone: _____

Is the referring physician enrolled in Medicaid? ☐ Yes ☐ No

Address of Referring Physician: _____

City: _____ State: _____ Zip Code: _____ County: _____

Other Physicians your child sees:

Name/Practice	Specialty	Phone

Diagnosis: _____

Insurance Information

Primary Insurance: _____

Mailing address for claims: _____

Customer service phone number: ( ) _____

Name of insured: _____

Member #: _____ Group #: _____

Secondary Insurance: _____

Mailing address for claims: _____

Customer service phone number: ( ) _____

Name of insured: _____

Member #: _____ Group #: _____

Health Information

Current medications:

Medication	Dosage/Frequency	Reason for Medication	Side Effects

Surgeries, Medical Procedures, Injuries, Hospitalizations, Special Tests (MRI, EEG, swallow study)	Date(s)	Location(s)

List any special equipment that your child has (e.g. walker, wheelchair): _____

_____

Are there any limitations with your child's: Vision: ☐ no ☐ yes Hearing: ☐ no ☐ yes Speech: ☐ no ☐ yes

If yes, describe: _____

Birth History

How many weeks old was your child at birth? _____ Birth weight: _____ Stay in NICU: ☐ no ☐ yes, how long? ____

Were there unusual problems during the pregnancy or delivery? ☐ no ☐ yes, describe: _____

Describe any problems noticed after birth: _____

_____

Family Information

Mother's Name: _____ Occupation: _____ DOB: _____

Fatherr's Name: _____ Occupation: _____ DOB: _____

Marital status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

List sibling(s) and age(s): _____

School and Therapy Information

Name of daycare, school, or program: _____ Placement/grade:_____

Does your child receive any services through the school? ☐ no ☐ yes If yes, describe: _____

Does your child have an Individualized Education Plan (IEP)? ☐ yes ☐ no

Does your child have a current physical therapy evaluation (less than 6 months old)? ☐ yes ☐ no

Please list other current therapy Provider(s):_____ Phone: _____