



Date: _____

General Information Form

Client's Information

Name of Client:

Date of Birth:

Gender:

Client's Home Telephone:

Client's Home Address:

Client's Medical Information

Referred By:

Diagnosis:

Reason for seeking OT services (Please provide some specific instances that have been of concern to you):

Pediatrician's Name:

Pediatrician's Phone:

Precautions/Medications:

Parents'/Caregivers' Information

Parents'/Caregivers' Names

Preferred Phone

Email

Emergency Contact Information

Emergency Contact

Contact Phone

Relationship to client