Date:_____

General Information Form

Client's Information	
Name of Client:	
Date of Birth:	Gender: Male / Female (circle one)
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