5 Stone Therapy | info@5stonetherapy.com | (704) 360-3900

NEW CLIENT FORM

Please ***complete form*** and ***email to info@5stonetherapy.com***

Client Name:_____

Insurance (Medicaid, Self-Pay, Private Pay):_____

Medicaid Number/Insurance Information:_____

Date of Birth:_____

Address:_____

Parent/Guardian:_____

Phone Number(s):_____

Parent/Guardian Email:_____

Primary Physician and Practice:_____

Physician's Phone Number:_____

Does the client have a medical diagnosis? (Example: Autism, ADHD, etc.):_____
_____
_____

Please list any complications with pregnancy or delivery:_____
_____

Please list any major surgeries or illnesses:_____
_____

Please list any precautions (include seizures):_____
_____

Does the client have any allergies or special diet?: _____
_____

Has the client received occupational (or other) therapy in the past? (yes/no): _____

If yes, please list details of therapist, dates, and location: _____
_____
_____

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Does the client currently receive any other therapy? (yes/no): _____

If yes, please list details of therapist, dates, and location: _____
_____

Does the client attend school or daycare? If yes, list:_____

Does the client have an IEP?: _____

Concerns/Reason for seeking OT: _____
_____
_____

What ideas can you give us to help us work with the client? (likes/dislikes): _____
_____
_____
_____

Please use this space below to add any additional information you would like us to know: