1. Please enter your information.

First Name: | Middle Initials: | Last Name: | Date of Birth:

Gender:
○ Male ○ Female

Referred by:

Legal Parent/Guardian Name (first, last)

Cell phone:

Text?
○ Yes ○ No

Home Phone:

Address:

Apt./Unit #:

Physician's Name:

Physician's Fax #:

2. Responsible Financial Party

Name: | Phone: | Email:

Address:

Apt. / Unit #:

3. Primary Insurance

Primary Insurance Name:

ID #: | Group #:

Policy Holder Name:

DOB:

Policy Holder Employer:

Okay to email reports:
○ Yes ○ No

4. Secondary Insurance

Secondary Insurance Name:

ID #: Group #:

Policy Holder Name: DOB:

Policy Holder Employer: Okay to email reports:
Yes No

Client Signature:

Signature Date

5.*MOVE Pediatric Therapy requires your child's physician's referral/prescription PRIOR to beginning services. We will obtain that information when Physician name and fax number is received.

Pediatric Health Questionnaire

6. First Name of Child: Last Name of Child:

DOB: Gender: Please select:
Biological Adopted Foster

Client lives with (list all those living in same household including ages of siblings):

7. MEDICAL HISTORY

Was child premature?
Yes No

Delivered at what gestational week?

Type of Delivery:
Vaginal C-section

List any complications with pregnancy/birth:

Medical Conditions:

Allergies:

Diagnosis given by MD and age given:

Medications:

8. SCHOOL/COMMUNITY

Name of School:

School District: Grade:

Services received currently:

Does your child have an IEP?

List any concerns your child is having with school:

List any concerns at home:

List concerns in community (stores, restaurants, playgrounds):

9. What is your goal for your child's therapy services?

	List Here
1	
2	
3	

10. What are your child's strengths?

What are your child's weaknesses?

What is your child's favorite toy or activity?

Any other comments or concerns not addressed above?