

THERAPY ZONE 4 KIDZ

Client Information

Date of Initial Visit: _____ Referred by: _____

Client's Name: _____ Date of Birth: _____

Parent's Name(s): _____

Address: _____ City: _____ Zip: _____

E-mail Address: _____

Current Grade/School: _____

School Services Currently in Place (IEP, 504 Plan, Speech, Resource, Adaptive P.E.):

Diagnosis (if any): _____

Who is Responsible for payment? _____

Parents Name (Mom /Dad) (please circle)	Home Phone	Cell Phone	Work Phone
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Parents Name (Mom /Dad) (please circle)	Home Phone	Cell Phone	Work Phone
	()	()	()

Which number should be called first to best reach you? _____

Is it O.K. to leave a confidential message at this number? (please circle): Yes No, just leave a call back #.

If parents live at two different addresses, please provide other address below:

Please list any Allergies, Precautions or Current Medications your child has (please include any food allergies):

Primary Concern(s) of the child/family:

- 1.
- 2.
- 3.