6030 Bethelview Rd Ste 10-160
Cumming, GA 30040
770-886-6204 fax 678-261-6421

Client Information

Name________________________________ Date of Birth: _________________________

Parents' Names: ____

Address: ____

Phone Number: _______________________ Cell Phone Number: __________________________

Email: ______________________________ Communication preference: home cell email

Diagnosis (if known): ____

Primary Physician: _________________________ Phone Number: _______________________

Physician's Address: ____

Referring Physician: _________________________ Phone Number: _______________________

Please list other specialists working with your child:

Name	Specialty	Phone Number

How did you hear about Building Bridges Therapy? ____________________________________

Insurance Information

Primary Insurance Company: ____

Person Insured: ____

Insurance Address: ____

Insurance Phone Number: ____

Group Number: ____________________ Policy Number: _____________________________

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Family History

Mother's Name: ______________________________ Date of Birth: ______________________

Occupation/Employer: ____

Father's Name: ______________________________ Date of Birth: ______________________

Occupation/Employer: ____

Marital Status: Single Married Divorced Separated Widowed

Brother(s), Sister(s), or others living with the child:

Name	Age

Why are you seeking the services of Building Bridges Therapy:

____

____

____

What is your biggest concern regarding your child?

____

____

Has your child previously received therapy services? yes no

If "yes", where and when: ____

Birth History and Development

Is your child adopted? yes no If so, at what age? ___________________________

Were there any complications during pregnancy (illness, injury, infection, etc)? If so, please describe:

____

____

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Were any medications taken during pregnancy or delivery? ________________________________

Location of Birth: _____________________________ Birth Weight: __________________________

Was pregnancy full-term? ____

Please describe labor (normal, long, induced, etc): ____

Describe delivery (normal, caesarean, breech, forceps used, etc): ___________________________

Please list any complications at birth:

____

____

Describe any congenital defect: ____

Does your child have any other medical issues:

____

____

Please list any hospitalizations and/or medical procedures you child has had:

____

____

Please list current medications:

Name	Dosage	Frequency	Reason for Medication

Please list any known allergies: ____

Please list any dietary restrictions: ____

Has your child ever had a psychological, developmental, neurological, psychiatric, EEG, or MRI evaluation? If so, why and what were the results?

____

____

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Speech and Language Developmental History

At what age did your child do the following:

Say single words: ______________________ Put 2-3 word together: ____________________

What were his/her first words? ____

Does your child understand or speak another language other than English?
____

Motor Development

At what age did your child do the following:

roll over: __________ crawl: __________ sit alone: __________ walk: __________

drink from cup: __________ chew solid food: __________ eat with utensils: __________

tie shoe laces: __________

Was the crawling phase prolonged, brief, or almost eliminated? ___________________________

Please check if your child is able to do the following:

Activity	Yes	No
Hop on one foot		
Skip with both feet		
Ride a bicycle		
Jump Rope		
Cut with scissors		
Color inside the lines		
Have consistent hand dominance		
Play with puzzles		
Type on computer		

Educational Information

Is your child currently in school? yes no Name of School: ____________________________

What days does your child attend school? ____

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Does your child receive any services through school? yes no If yes, what services?

____

____

Does your child have a current Individual Education Plan? yes no If yes, please provide a copy.

Social/Emotional History

What are your child's favorite toys/activities?

____

____

How does your child play with other children?

____

____

Is your child currently enrolled in any community activities?

____

____

Is there anything else we should know about your child or family?

____

____

Preferred day and time for therapy: ______________________________________

______________________ ______________________ ____________

Name of Person Completing Form Relationship to Child Date