P.O. Box 670207 Marietta, GA 30066
Office 770-643-0868, Fax 770-643-0869
www.koolkidzpt.com

HISTORY AND INFORMATION FORM

Child's Name _____ Child's DOB _____Sex___ Home Phone _____

Mother's Name _____ Mother's DOB _____ Cell Phone _____

Father's Name _____ Father's DOB _____ Fax No. _____

Family's Address _____ City _____ Zip _____

Mother's Occupation _____ Work Phone _____ E-mail address _____

Father's Occupation _____ Work Phone _____ Child's School/Daycare _____

Child's Diagnosis _____ Referring Physican _____ Physician's Phone_____

Physican's Address:_____

Name of Insurance Company _____ Insurance Co. Phone _____

Send claims to this address _____

Name of insured _____ Insured Identification # _____ Policy # _____

Group # _____ Is this child covered under another insurance policy? _____ yes ____ no

Please provide any secondary insurance information on the back of this form

Siblings, ages _____

Date of last Physical/Occupational Therapy Evaluation _____ Are your child's immunizations up to date?_____

Does your child have any know allergies? _____ If yes, please specify _____

Was your child born prematurely? If so, at what gestational age was he/she born? _____

Was your child required to say in the NICU following birth? If so, for what reason(s) and how long?

_____

What would you like your child to accomplish as a result of receiving physical/occupational intervention? _____

_____

Is there anything else your therapist should know regarding your child that might assist her in working with you child? _____

_____