



Occupational Therapy Department
450 30th Street, 4th Floor
Oakland CA 94609
Tel. 510-869-8925
Fax 510 869-6951

Client Data

Name of child: _____ **Date:** _____

Birth date: _____ **Age:** _____

Mother's name: _____ **Father's name:** _____

Address: _____
(Street) (City) (Zip Code)

Home phone: _____ **E-mail:** _____

Primary physician: _____ **Referred by:** _____

Name of school or daycare: _____ **Grade level:** _____

Presenting problems:

Precautions:

Medications (presently taking or as needed):

Testing or treatment done previously, or in progress:

A. Medical:

B. Psychological:

C. Educational:

Other pertinent information:

Release of Information

I _____ give my permission to Ginny Gibson, OTR/L
(print)
to obtain the medical or educational records of my child, _____.
(print name of child)

(Parent Signature)

(Date)