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:

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)