



PEDIATRIC OCCUPATIONAL THERAPY CLINIC

450-30th Street • Oakland, CA 94609

Phone (510) 869-8925 • Fax (510) 869-6951

CLIENT DATA FORM

Date _____ Child's Name _____ Birthdate _____

How did you hear about our clinic?

Contact Information	
Parent(s)/ Legal Guardian _____	
Home Phone _____	Cell Phone _____
Address _____	
Email _____	Preferred Contact Method _____

Medical History			
Prematurity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cervical Spine Instability	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shunt	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma / Hayfever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bladder problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bowel Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea / constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrostomy Tube	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Medical Diagnoses _____			
Medications _____		Allergies _____	
Surgeries (type and date) _____			

School Information	
School _____	Grade _____
Special Services _____	

Presenting Concerns

(If you need additional space to answer these questions, please attach additional pages.)

Why are you seeking occupational therapy services for your child?

What other therapies or special services is your child currently receiving?

What therapies, special services, or testing has your child received in the past?

Does your family have any special cultural or spiritual practices that you would like us to follow while you are here? Yes No

If yes, please explain:

What are your child's favorite play activities? Areas of strength?

Is there anything else you feel we need to know about your child?

Scheduling Preferences

There are 3 start times for clinic. Clients will be enrolled on a first-come, first-served basis.

Please indicate your child's availability:

1:30 to 2:20pm Yes No 2:30 to 3:20pm Yes No 3:30 to 4:20pm Yes No

Please **return completed forms** by mail, fax, or email to:

Robyn Wu • Occupational Therapy Department • Samuel Merritt University
450-30th Street, 4th Floor • Oakland, CA 94609

FAX: 510-869-6951 • Email: rwu@samuelmerritt.edu