Achieve
Pediatric Therapy & Rehab

Patient Intake/History Form

General Information		
Patient Name:		
Sex: M F	Date of Birth: Mo: Day: Yr:	
Primary Care Physician:		
Parent's Name:		
Address:	Phone: Home	Work:
City:	State:	Zip:
Emergency Contact:	Relationship:	Phone:
Reason for therapy referral:		
Known Allergies:		
Current Medications:		
Medical/Surgical History(Prior hospitalizations, surgeries):		
Childhood Diseases:		

Patient Intake/History Form cont.

Please specify any religious/cultural considerations:

____

Is there anything we need to know that is not covered on this form? If so please explain:

____

Patient's goals for treatment:

____

_________________________________ _________________________

Patient or Parent/Guardian Signature Date

IN CASE OF AN EMERGENCY, PLEASE PERFORM ANY LIFE SAVING TECHNIQUE (I.E. CPR, HEIMLICH MANUEVER) THAT YOU DEEM NECESSARY IN ORDER TO PRESERVE THE LIFE OF MY CHILD.

_________________________________ _________________________

Parent/Guardian Signature Date

How did you hear about us?

_____Doctor referral ______Internet _____Current patient/friend

Other: ______________________________