Movin' & Groovin' Children's Therapy Services, Inc.
17 Interlochen Drive
Atlanta, GA 30342
Phone: 404-918-1828
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Annual Client History Form

General Information

Child's Name:_____

Child's Date of Birth:_____

Sex: M or F

(circle) Parent Guardian Foster Parent(s):

Address:_____

City:_____

State:_____

Zipcode:_____

County:_____

Home Telephone:_____ Work Telephone:_____ Cell phone:

Fax telephone:_____Pager:_____EMAIL:_____
Emergency Phone:_____contact person:_____

Referring Physician:_____

address:_____phone:_____

Reason for referral:_____

List all your child's diagnoses and the date they were received:_____

Pediatric Primary Care Physician:_____

Other consulting physicians involved in your child's case:

Name:_____Phone:_____
Name:_____Phone:_____
Name:_____Phone:_____
Name:_____Phone:_____

Name and phone number of the physician that you would list as the "team leader of your health care team:
_____

PRIMARY INSURANCE:

Mother's occupation/employer:_____

Father's occupation/employer:_____

Name of Insured:_____

Insurance Company_____Phone:_____

Policy number:_____

Group Number:_____

Secondary insurance:_____

Policy number:_____

Group number:_____

Send Claims to (address and phone ON CARD):_____
Phone:_____

Medical History:

Is your child taking any medications? Please specify which ones._____
_____

Are your child's immunizations up to date?_____

Does your child have any known allergies?_____

Is your child allergic to latex or rubber?_____

Is your child allergic to non-citrus fruits?_____

Does your child have any medical complications that the therapist should be aware of:
If yes, please specify:_____
_____

Describe any precautions that should be taken with your child due to medical reasons:_____
_____

Please list any surgeries (include dates) that your child has had:_____
_____

Birth History:
Was the child born early or late? If so, by how many weeks? _____

Was the delivery c-section?_____
Please describe any unusual problems during the birth process:_____

Typical Day:

Does your child receive other private therapy intervention elsewhere (do not include public school)? If so, where? How often? And list the name of the therapist and phone numbers:_____
_____
_____

Please see attached weekly schedule and fill out typical day activities on the schedule (naps, mealtimes, school hours, therapy visits, time in stander, etc.

Please list your *current* home activities/exercises/ homework your therapists have recommended for your child:

_____
_____
_____
_____
_____
how often or what duration is recommended?
_____
Are you able to complete them?_____if not, what barriers do you notice are preventing their completion?_____
_____
_____
_____

In your opinion, what are your child's primary, immediate challenges with function in your home, within your family, and within the community?_____
_____
_____
_____
_____

What are your short term goals for physical therapy intervention (in 6 months):
1.

2.

3.

What are your long term goals for physical therapy intervention: (in one year):
1.

2.

What is the name of your child's school, daycare, or preschool? (if applicable):_____

Signature of parent of guardian Date