Roc OTx Pediatric Occupational Therapy

New Patient Form

*Required

Child's First and Last Name:*

Child's D.O.B:*

Biological Sex:

- ☐ Male
- ☐ Female

Preferred Gender Identity:

- ☐ Male
- ☐ Female
- ☐ Other

Primary reason you are seeking OT for your child?*

Please list any diagnoses your child has received*

Primary Physician's Name and Practice Name*

Physician's Address and phone number*

Has your child received an Occupational Therapy evaluation?*

- ☐ Yes
- ☐ No

If yes, where and when?

Has your child received a Speech-Language evaluation?*

- ☐ Yes
- ☐ No

If yes, where and when?

Has your child received a Physical Therapy evaluation?*

- ☐ Yes
- ☐ No

If yes, where and when?

Is there anything else you would like us to know about your child?

Signature: _____

Date: _____