

**CLIENT INFORMATION FORM**

TODAY'S DATE       CHILD’S DATE OF BIRTH

CHILD'S NAME       FAMILY E-MAIL

INSURED PARENT/PARTY OTHER PARENT

|  |  |
| --- | --- |
| NAME: | NAME: |
| ADDRESS: | ADDRESS: |
| CITY:       ZIP: | CITY:       ZIP: |

Check box next to preferred phone number

|  |  |
| --- | --- |
| PHONE (H) | PHONE (H) |
| (W)      EXT | (W)      EXT |
| (C) | (C) |
| DATE OF BIRTH: | DATE OF BIRTH: |
| OCCUPATION: | OCCUPATION: |
| EMPLOYER: | EMPLOYER: |
| ADDRESS: | ADDRESS: |
| CITY/ST/ZIP: | CITY/ST/ZIP: |
| INSURANCE CO: | SECONDARY INSURANCE CO: |
| ADDRESS: | ADDRESS: |
| CITY/ST/ZIP: | CITY/ST/ZIP: |
| GROUP#:       ID#: | GROUP#:       ID#: |
| SS#: | SS#: |

Any other health benefit plan? (i.e. Family Resources, etc.):

**PERSON RESPONSIBLE FOR PAYMENT (PLEASE ADD ADDRESS AND INSURANCE INFO IF DIFFERENT THAN ABOVE):**

NAME:

ADDRESS:       CITY:       STATE:       ZIP:

|  |
| --- |
| PHONE: (H)      (W)  EMPLOYER: |
| ADDRESS:       CITY:       STATE:       ZIP: |
| INSURANCE CO: |
| ADDRESS: |
| CITY/ST/ZIP: |
| GROUP#:       ID#: |
| SS#: |

Your signature below authorizes COTI to release any & all pertinent information to your insurance company and physician to assist in claim approval.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE COMPLETE NEXT PAGE

**I AM INTERESTED IN:**  Occupational Therapy  Speech Therapy

**WHAT IS THE MAIN CONCERN THAT BRINGS YOU TO COTI:**

**FAMILY HISTORY:**

Is your child adopted or fostered?

Adults in home

Siblings & Age

**MEDICAL BACKGROUND:**

Current Diagnosis (if any)

Medications currently taken

Allergies & Type of reaction

Seizures (past/present)

Special precautions

**RELATED PROFESSIONALS:**

**PRIMARY CARE PHYSICIAN** Send progress reports yes no

ADDRESS       CITY      STATE     ZIP       EMAIL:

PHONE

**OTHER PROFESSIONALS:**

NAME       SPECIALTY

ADDRESS       CITY      STATE     ZIP

PHONE

NAME       SPECIALTY

ADDRESS       CITY      STATE     ZIP

**SCHOOL**

School currently attending      Grade

Contact Person       Title       Phone

Current school related services: (OT, Speech, Resource Teacher, etc):

**OTHER ACTIVITIES** (sports, music lessons, etc):

I would prefer: 1st Available  Rockwern (students only)  CHDS(students only)

Blue Ash  OVV(students only)  7Hills(students only)

CCS in Fairfield  St.Rita(students only)  CCDS(students only)

Presbyterian Preschool  MVCA(students only)

**PLEASE USE THE PULL DOWN MENU TO INDICATE BELOW YOUR PREFERENCE FOR THERAPY TIMES (FOR EVALUATION AND TREATMENT IF INDICATED):**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | MON | TUES | WED | THURS | FRI | SAT |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 8:00-10:00 |  |  |  |  |  |  |
| 10:00-12:00 |  |  |  |  |  |  |
| 12:00-3:00 |  |  |  |  |  |  |
| 3:00-6:00 |  |  |  |  |  |  |