

Children's Therapy Group, Inc.
Providing Pediatric Speech, Occupational, and Physical Therapy
65 Darcee Court Lawrenceville, GA 30045
(678) 858-4777
childrenstg@yahoo.com

Client Information

Name: _____ DOB: _____

Age: _____ Gender: _____ Parents/Guardians: _____

Home Phone: _____ Work Phone: _____ (Mother)
Cell Phone or email: _____ (Father)

Address: _____

Physician: _____ Phone: _____
Group/Facility Name: _____

Does your child have a medical diagnosis? ___Yes ___No If yes, explain

Is your child under the care of any other physicians, therapists, or specialists? ___Yes
___No If yes, explain _____

Are there any medical precautions that need to be taken during the treatment of your
child? ___Yes ___No If yes, explain _____

Has your child received previous therapy (Speech, OT, PT)? ___Yes ___No If so, how
long? _____

What are your concerns regarding your child's
development? _____

What would you like to see your child be able to do as a result of receiving therapy
(Speech, OT, PT) ? _____