CLIENT INFORMATION SHEET

Identifying Information

Client's Name: _____

Client's Nickname: _____Date of Birth: _____ Gender: _____

Client's Ethnicity: _____

Diagnoses: _____

Diagnoses given by: _____ Date:_____

Parent 1 Name: _____ Parent 2 Name: _____

Marital Status: _____Child Lives with: _____

Client's Legal Guardian: _____Relationship to Client: _____

Holder of Educational Rights: _____Relationship to Client: _____

Other Pertinent Information Regarding Client's Legal Status (e.g., custody, conservatorship, etc.)

_____

Client's Primary Language: _____ Parent's Primary Language: _____

Primary Residential Address:

_____

City: _____ State: _____ Zip: _____

2nd Residential Address (if applicable):

_____

City: _____ State: _____ Zip: _____

Mailing Address (if different from Residential Address):

_____

City: _____ State: _____ Zip: _____

Telephone and E-mail Addresses:

Adult Clients: Email Address: _____

Cell Phone: _____ Work Phone (if okay to call): _____

For Minors:

Mother's Cell Phone: _____ Mother's Work Phone: _____

Father's Cell Phone: _____ Father's Work Phone: _____

Mother's E-mail Address: _____

Father's E-mail Address: _____

Primary Contact for Scheduling: _____

All Clients:

Emergency Contact Name: _____

Relationship to Client: _____ Phone:_____

Medical Information

Client's Primary Care Physician:_____

Physician's Phone:_____

Please list any allergies: _____

Is there anything else you would like us to know about you or your child (any other special health concerns)?

_____

Regional Center Information:

Regional Center: _____

Service Coordinator's Name: _____ Phone: _____

School Information:

School District: _____

Client's School: _____ Grade: _____

School Address:_____

School Phone: _____

Teacher's Name: _____ Email: _____

Child in the process of being evaluated for Special Education Services (e.g. IEP or 504)?: _____

Does Child have IEP or 504?:_____ If No, is eval. in process or about to start?:_____

IEP Eligibility: _____fa_____ Date of most recent IEP:_____

Services: _____

_____

Case Manager: _____ Email: _____

Are you concerned about your child's education and want a referral for advocacy services?: _____

Other Professionals:

Advocate/Attorney: _____ Phone: _____

Speech Therapist: _____ Phone: _____

Occupational Therapist: _____ Phone: _____

Other: Name & Title:_____ _____Phone: _____

Additional Information you would like to share: _____

_____

_____

_____