

ADD Austin
503 West 38th Street
Austin, TX 78705

GENERAL INFORMATION

NAME: _____ DATE: _____

SEX: Male Female BIRTHDATE: _____ AGE: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #s: Home: _____ Work: _____

Cell: _____ Other: _____

EMAIL: _____

PARENT/GUARDIAN (if minor): _____

PREFERRED METHOD OF CONTACT: home cell work text email

EMERGENCY CONTACT: _____

PHONE: _____ RELATIONSHIP: _____

HOW DID YOU HEAR ABOUT ADD AUSTIN? _____

PRIMARY CARE PHYSICIAN or PEDIATRICIAN:

Name: _____ Phone: _____

Address: _____

PSYCHIATRIST:

Name: _____ Phone: _____

Address: _____

NEUROLOGIST:

Name: _____ Phone: _____

Address: _____

General Information – Part 2
Children & Adolescents

Child's nickname or preferred name: _____

Child's handedness (circle one): right left ambidextrous

Are any of the child's blood relatives left-handed or ambidextrous? Yes No

If so, whom? _____

SCHOOL HISTORY

1. Please list all schools the child has attended (preschool – current):

GRADE	SCHOOL	DISTRICT

2. Which subjects are strengths for your child?

- Reading Math History
- Writing Art Foreign Language (if applicable)
- Spelling Gym Other: _____

3. Which subjects are weaknesses for your child?

- Reading Math History
- Writing Art Foreign Language (if applicable)
- Spelling Gym Other: _____

OTHER INFORMATION

1. What are your child's personal strengths and weaknesses?

a. Strengths: _____

b. Weaknesses: _____

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

3. What questions or concerns do you have about the therapy/assessment?

Thank you for completing this questionnaire. We look forward to meeting you and your child.