Empowering Steps Movement Therapy (ESMT)
Intake for Assessment 2018 – 2019

CLIENT'S (CHILD) NAME _____ **Today's Date:** _____

D.O.B __/__/__ **AGE** ____ **MALE** ☐ **FEMALE** ☐
MM DD YYYY

PARENT/GUARDIAN NAMES _____
PHONE # _____ **CELL PHONE #** _____

EMAIL ADDRESS _____ **Language spoken at home:** _____
DIAGNOSIS

_____ _____

MEDICATION YES ☐ **NO** ☐ If yes please list.

_____

Verbal ___ / **Non Verbal**___ **Walking**___/**Non Walking**____ **Vision Impairments** _____
Hearing Impairments_____ **How did you hear about us?** _____

BEHAVIORAL CONCERNS

_____

Sensory Integration☐ **Behavioral Issues**☐ **Low muscle Tone**☐ **Mobility Issues**☐
Other _____
Formal Assessments Completed? (Fine/gross motor or multi discipline etc.)

Informational Reports Completed by Professionals
By whom _____ **Date** _____ **Please bring to assessment.**

WHO WILL BE BRINGING CLIENT? To assessment?_____**To sessions?**_____

MCFD_____ **Private**_____ **Other** _____

Client Availability: **A= Assessment S= Sessions**

Monday	Tuesday	Wednesday	Thursday	Friday	Sunday
A: S:	A: S:	A: S:	A: S:	A: S:	A:12:30pm S:

Club Aviva Availability:

Monday	Tuesday	Wednesday	Thursday	Friday	Sunday

THERAPIST(s) _____ ☐ **Confirmed**

DAY & TIME OF ASSESSMENT _____ ☐ **Confirmed**