mOTivation
Occupational Therapy, LLC
Cynthia Heister, MS, OTR/L, CAS
PO Box 186
12339 William Penn Hwy
Thompsontown, PA 17094
www.motivationot.com
heisterot@yahoo.com
(717) 513-7601

New Patient Form

Child's name_____DOB_____

Parent/Guardian(s) name(s)_____

Address_____

Phone and Email_____

School (if applicable)_____

Diagnosis (if applicable)_____

Physician Name and Address_____

Areas(s) of concern_____

Child's Strengths_____

Recent hospitalizations or surgeries_____

Does your child have:

Allergies	Y N	Frequent Falls	Y N
Feeding Problems	Y N	Depression	Y N
Vision Problems	Y N	Anxiety	Y N
Hearing Problems	Y N	Behavior Problems	Y N
Heart Defects	Y N	Recent Fractures	Y N
Breathing Difficulties	Y N	Weight-bearing Problems	Y N
Difficulty Sleeping	Y N	Overly Active	Y N

If yes to any above, please provide more details_____

_____

_____

Any other information I should know before treating your child_____

_____

_____

*I attest the above information is correct and accurate.

Parent/Guardian name (print)_____

Signature_____Date_____

Thank you for choosing mOTivation Occupational Therapy.