

Caregiver and Client Record Form

Person Filling the Form: Name	Relation to Child	Email address and Phone Number	Date Form is Filled

Personal Information

Child's Name		Date of Birth	
Mother's Name		Father's Name	
Age		Gender	
Weight		Date of Diagnosis	
Siblings		Doctor's Name	

Child's Way of Communication	Verbal	Few words	Nonverbal	Signs/ gestures	PECS	AAC
Check off the appropriate box.						

Specific Information:

	At 2-3 yrs /At the time of the Diagnosis	As of Now
Sleep		
Appetite		
Water intake		
Toileting		
Activity Level		
Comprehension		
Sensitivities		
Other Medical conditions		
Any Self – harm Behaviours		
Any Aggressive Behaviours		
Main Daily Activities		

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Family Doctor – Name	Specialization	Address	Phone number

Current Situation/ Approaching For:

Current Pharmacy: Name	Phone #	Address

Current Medicines (including supplements) and dosage with how many times a day it's taken:

Any other information you would like to add: