Confidential Client Application

Cambridge Center for Neuropsychology

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Office 617.-354-5050 Email: info@cambridgeneuropsych.com

Child's Name	First Middle Last		
Age		**Date of Birth**	
School		**Grade or Program**	
Parents			
Home Address	# Street City State Zip		
Home Telephone			
Cell Phone			
Email			
School Address	# Street City State Zip		
School Contact/s	**Teacher (Name/phone/email)**	**Other (Name/phone/email)**	
Pediatrician		**Address/phone/email:**	
General Physical Condition			
Who referred you to our center?			
Please describe the concern that brought you to our office.			
Have you sought help for this problem in the past?			
Prior Evaluations (Date & Type of Evaluation)			

Family Information				
	Parent/Guardian		**Parent/Guardian**	**Guardian/Other Caretakers**
Name				
Address (if different)				
Home Telephone				
Work Telephone				
Cell Phone				
Email				
Fax Number				
Birthdate				
Age				
Education and Occupation				
Place of Business				
Marital Status / How Long?				
Nationality				
Health				
Siblings and Others Living in the Home				
Name	**Age**	**Relationship**	**Grade/School**	**Academic/Medical History**
Pets (kind and name)				
Primary languages spoken at home and in extended family, or cultural information that may be relevant:				

Educational History					
Grade	**Age**	**Year**	**School**	**IEP**	**Special Education Supports S/L, OT, PT, Tutoring Provided**
Preschool					
Kindergarten					
Grade 1					
Grade 2					
Grade 3					
Grade 4					
Grade 5					
Grade 6					
Grade 7					
Grade 8					
Grade 9					
Grade 10					
Grade 11					
Grade 12					
College					

Additional information that you feel would help us gain a better understanding of your child or your family.

Please feel free to provide any additional information below. We encourage parents to tell us what your main goals are for your child's current evaluation. Describe any questions you may have about your child's learning, as well as strengths and/or concerns (i.e., at school, home, socially, medically):

Please sign below, indicating you have understood and agree with the information contained in this client information packet, and that you will be personally responsible for the payment of fees. In cases where there is joint financial responsibility and/or joint custody, both parents must personally sign below.

Information Regarding Services and Fees _____

General information Regarding Evaluations _____

Name (Print): Signature:	Date:
Relationship to Patient:	
Name (Print): Signature:	Date:
Relationship to Patient:	