OCCUPATIONAL THERAPY DRIVER REHABILITATION PROGRAM

CLIENT INFORMATION FORM

FOR CLIENT TO COMPLETE AND FAX/EMAIL

Date:_____

Last Name: _____ First Name: _____ Middle Initial: ___

Male: □ Female: □ SSN: _____ Email: _____

Language: English: □ Spanish: □ Korean: □ Other:_____

Cell Phone #:_____ Home Phone #: _____ Rancho #: _____

Address:_____

City:_____ State:_____ Zip Code: _____

Date of Birth: _____ Age: _____ Birthplace: _____ Race:_____

Marital Status: _____ Name of Spouse: _____

Emergency Contact Name: _____ Relationship: _____

Phone #_____

Insurance/Coverage: MediCAL: □ MediCARE: □

Other Insurance: _____

California Children's Services Medical Therapy Unit Name:_____

License status: Never had: □ ID only: □ Permit: □ License: □

Valid: □ Expired: □ Suspended: □ Unknown status: □

License/Permit/ID #:_____ Expiration Date: _____

Referred to the DMV Driver Safety Office: Yes: □ No: □ Unknown: □

El Segundo:□ Commerce:□ Covina:□ Orange:□ Van Nuys:□ Other:_____

Transportation: Driving: □ Family/Friends: □ Bus/Train: □ Metro Access: □

Other:_____ Disabled Person Parking: □

Referral Source: Physician: □ Therapist: □ DMV: □ Family: □ Self: □

Friend: □ Brochure: □ Other: _____

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