

# SPLASHERS CLIENT INFORMATION AND GOALS

Date: \_\_\_ / \_\_\_ / \_\_\_

CLIENT: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

What is your child's main form of mobility at present? \_\_\_\_\_

How does your child communicate? \_\_\_\_\_

Parent/Carer preferred name: \_\_\_\_\_ Preferred phone number: \_\_\_\_\_

Address: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

## SPLASHERS GOALS



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.....  
Therapists to complete this section:

## RELEVANT ASSESSMENT FINDINGS

(subjective and objective, please also include relevant history)