# REGISTRATION INFORMATION

Child's Name: ______________________________

Date of Birth: ______________________________

Street Address: ______________________________

City: ______________ State: ______ Zip: ________

Home Telephone #: ______________________________

Parent/Caregiver 1: ______________________________

Cell #: ______________ Work #: ______________

Email Address: ______________________________

Parent/Caregiver 2: ______________________________

Cell #: ______________ Work #: ______________

Email Address: ______________________________

Medical Diagnoses (If any): ______________________________

Allergies: If your child has an allergy, we ask that you complete and additional form. Please request Health History for a Child with Allergies.

Physician: ______________________________

Address: ______________________________

Telephone #: ______________________________

# Developmental and Medical History

Has your child had seizures? Yes No Age: ________________

Type: ______________________ Frequency: ______________________

Any present medication(s)?

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

Has your child had a history of ear infections?

If yes, frequency: ______________________________

Are there any other medical precautions the therapist should know about when working with your child?

_______________________________________________

_______________________________________________

_______________________________________________

Were there any pregnancy or birth complications? Prematurity?

_______________________________________________

_______________________________________________

## Developmental Skills

**Can your child:**

| | | | |
|---|---|---|---|
| 1. | climb on playground equipment? | Yes | No |
| 2. | throw a ball? | Yes | No |
| 3. | catch a ball? | Yes | No |
| 4. | complete interlocking puzzles? | Yes | No |
| 5. | dress self? | Yes | No |
| 6. | put on socks/shoes? | Yes | No |
| 7. | tie shoes? | Yes | No |
| 8. | print uppercase letters? | Yes | No |
| 9. | print lowercase letters? | Yes | No |
| 10. | kick a ball? | Yes | No |

# School Information

Name of School: ____________________

Teacher: ____________________ Grade: ________

☐ Regular Education ☐ Special Education

Favorite Subject: ____________________

Least Favorite Subject: ____________________

| Challenges at School | How concerned are you? Not at all | | | | Very |
|---|---|---|---|---|---|
| Reading | 1 | 2 | 3 | 4 | 5 |
| Math | 1 | 2 | 3 | 4 | 5 |
| Spelling | 1 | 2 | 3 | 4 | 5 |
| Attention Span | 1 | 2 | 3 | 4 | 5 |
| Restlessness | 1 | 2 | 3 | 4 | 5 |
| Handwriting | 1 | 2 | 3 | 4 | 5 |
| Poor organization | 1 | 2 | 3 | 4 | 5 |
| Task completion | 1 | 2 | 3 | 4 | 5 |
| Following directions | 1 | 2 | 3 | 4 | 5 |
| Memory | 1 | 2 | 3 | 4 | 5 |

| Challenges at Home | How concerned are you? Not at all | | | | Very |
|---|---|---|---|---|---|
| Regularity of sleep | 1 | 2 | 3 | 4 | 5 |
| Bathroom routines | 1 | 2 | 3 | 4 | 5 |
| Mealtime behavior | 1 | 2 | 3 | 4 | 5 |
| Adaptation to change in routine | 1 | 2 | 3 | 4 | 5 |
| Socialization with peers | 1 | 2 | 3 | 4 | 5 |
| Resistance to new people/situations | 1 | 2 | 3 | 4 | 5 |
| Frustration tolerance | 1 | 2 | 3 | 4 | 5 |
| Mood | 1 | 2 | 3 | 4 | 5 |
| Regulating activity level | 1 | 2 | 3 | 4 | 5 |
| Homework | 1 | 2 | 3 | 4 | 5 |
| Following directions | 1 | 2 | 3 | 4 | 5 |
| Sibling conflict | 1 | 2 | 3 | 4 | 5 |
| Flexibility | 1 | 2 | 3 | 4 | 5 |
| Transitions | 1 | 2 | 3 | 4 | 5 |

# Other Information

1. What are your child's strengths?

2. What would you like your child to achieve through occupational therapy?

3. How does your child feel about himself or herself?

4. Is there anything else you would like us to know about your child?

## Services Currently Receiving

| Service(s) | Provider | Telephone |
|---|---|---|
| ☐ Occupational Therapy | | |
| ☐ Physical Therapy | | |
| ☐ Speech and Language | | |
| ☐ Psychology | | |
| ☐ Psychiatry | | |
| ☐ School Aid | | |
| ☐ Other | | |

## Daily Schedule

1. My child is in school from ___________ to ____________ .

2. Please describe your child's morning routine (typical school day). What factors most interfere with a smooth morning?

______________________________________________

______________________________________________

______________________________________________

______________________________________________

3. Please describe your child's usual after-school routine (overview). What are the biggest deterrents to a smooth evening? (Discuss specifics of homework below.)

______________________________________________

______________________________________________

______________________________________________

4. Please describe your current approach to your child's homework. What prevents or facilitates smooth homework sessions? How involved are you in the process?

______________________________________________

______________________________________________

______________________________________________

______________________________________________

# Daily Schedule, con't

5. What after-school activities is your child involved in? Why? Are you happy with those choices?

6. How does your child choose to spend his/her free time?

7. Does your child play appropriately with toys? Yes No If not, explain:

8. Please describe your child's bedtime routine. What tends to relax or over stimulate him/her in the evening? How long does it take your child, once put to bed, to fall asleep?

9. Who is primarily responsible for discipline and rule setting at home? What methods are most effective? How does your child respond to discipline?

## Daily Schedule, con't

10. Does your child tantrum? Yes No How often? ______________________
    Have you observed any head banging or self-destructive behavior? Yes No
    If yes, explain:

    ______________________________________________
    ______________________________________________
    ______________________________________________
    ______________________________________________
    ______________________________________________

11. How does your child respond to authority figures outside of the home?

    ______________________________________________
    ______________________________________________
    ______________________________________________
    ______________________________________________
    ______________________________________________

12. How does your child cope with weekends (e.g. more physically active, stays in front of the TV, gets together with friends, demeanor compared to week days)?

    ______________________________________________
    ______________________________________________
    ______________________________________________
    ______________________________________________

13. What is her/his mood like when s/he returns to school after the weekend?

    ______________________________________________
    ______________________________________________
    ______________________________________________

14. How does your child respond to structure? Please elaborate:

    ______________________________________________
    ______________________________________________
    ______________________________________________
    ______________________________________________

# Social Skills

1. Does your child have a “best friend”? Yes No
   Older or younger? ______________________ Age _______ Sex _______
   If yes, what qualities of that child do you feel attract your child to the friend?

   ______________________________________________
   ______________________________________________
   ______________________________________________
   ______________________________________________

2. Is your child attuned to social cues? Is s/he socially appropriate (at school, home, play date, party)?

   ______________________________________________
   ______________________________________________
   ______________________________________________
   ______________________________________________

3. How does your child do with play dates? Does s/he request them?

   ______________________________________________
   ______________________________________________
   ______________________________________________
   ______________________________________________

4. How does your child function at birthday parties, other group or crowded situations (e.g. guests at home, visiting friends or relatives, youth group, synagogue/church, mall, movie theatre, etc.)?

   ______________________________________________
   ______________________________________________
   ______________________________________________
   ______________________________________________
   ______________________________________________

4. If your child has siblings, how does s/he relate and play with them?

   ______________________________________________
   ______________________________________________
   ______________________________________________