



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 an 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?

Does your child attend:

- Nursery School/Preschool: _____
- Early Intervention Program: _____
- Regular Education Special Education

Developmental Skills

Please circle **all of the items** your child can perform. Each of the following skills typically develops around the ages indicated; however, these ages are merely a guide and are not definitive.

(36-42 mo.)

- | | | |
|---|-----|----|
| 1. Walk up and down stairs with alternating feet? | Yes | No |
| 2. Climb on playground equipment? | Yes | No |
| 3. Throw a ball? | Yes | No |
| 4. Catch a ball? | Yes | No |

5. Kick a ball?	Yes	No
6. Draw lines and circles?	Yes	No
7. Undress self with some help?	Yes	No
8. Pour liquid from a small container?	Yes	No
9. Understand concepts such as "behind" & "next to"?	Yes	No
10. Run with arms moving back and forth?	Yes	No
11. Cut paper into 2 pieces?	Yes	No
12. Trace a horizontal line?	Yes	No
13. Unbutton large buttons?	Yes	No
14. Ride a tricycle using pedals?	Yes	No
15. Make sharp turns around corners when running?	Yes	No
16. Use the toilet independently?	Yes	No
17. Wash and dry hands independently?	Yes	No
<i>(42-48 mo.)</i>		
18. Hop forward on one foot, then the other foot?	Yes	No
19. Dress with some help?	Yes	No
20. Button large buttons?	Yes	No
21. Carry out a series of 3 directions?	Yes	No
22. Paint with a crayon/brush covering a whole page?	Yes	No
23. Know how to take turns in games?	Yes	No
24. Play make-believe games with other children?	Yes	No
25. Cut across and down paper with scissors?	Yes	No
<i>(48-60 mo.)</i>		
26. Copy square shapes?	Yes	No
27. Draw a person with two to four body parts?	Yes	No
28. Use scissors to cut straight lines within $\frac{1}{4}$ "?	Yes	No
29. Draw squares?	Yes	No
30. Copy some capital letters?	Yes	No
31. Copy triangles and other shapes?	Yes	No
32. Complete a forward roll accurately?	Yes	No
33. Compare different textures, like soft & smooth?	Yes	No
34. Name heavier of two objects in hands?	Yes	No

Early Childhood - ages 3-5

35. Hop on one foot?	Yes	No
36. Use a fork and spoon?	Yes	No
37. Dress and undress without help?	Yes	No
38. Wash self without help?	Yes	No
39. Draw a person with body?	Yes	No
40. Write his/her name?	Yes	No

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
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

Services Currently Receiving

Service(s)	Provider	Telephone
<input type="checkbox"/> Occupational Therapy		
<input type="checkbox"/> Physical Therapy		
<input type="checkbox"/> Speech and Language		
<input type="checkbox"/> Psychology		
<input type="checkbox"/> Psychiatry		
<input type="checkbox"/> School Aid		
<input type="checkbox"/> Other		

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?

Daily Schedule

1. My child is in school from _____ to _____ on _____.

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

Four horizontal lines for writing the answer to question 2.

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

Four horizontal lines for writing the answer to question 3.

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

Four horizontal lines for writing the answer to question 4.

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

Three horizontal lines for writing the answer to question 5.

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

Three horizontal lines for writing the answer to question 6.

7. 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?

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

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

10. 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 weekdays)?

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

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

Social Skills

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

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

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