REGISTRATION FORM

Please fill out this form as best as you can.

Today's date: _____

Child's First and Last name: _____ Birth Date: _____ Age: _____

Parent/Legal Guardian's Name: _____Relationship to Child: _____

Address: _____ CITY: _____ State/Zip: _____

Phone: _____ Cell phone: _____ Email: _____

Pediatrician: _____ Phone: _____

Employer: _____ Address: _____

Referred By: _____

Name of school district /program your child is enrolled: _____

Name of case manager: _____

Regular school: _____ Grade: _____

Special education class: _____ Classification: _____

Does your child have a diagnosis? _____

_____

What is your main concern about your child? _____

_____

How long has it been a problem? _____

_____

Is your child getting any help /services?_____

_____

Medical History:

Any medical problems or complications during pregnancy: Y/N If yes, please explain: _____

_____

Medications during pregnancy: _____

Full term: Yes/No Premature: Yes/No If yes, how premature? _____
Birth Weight: _____ Apgar score: _____

Any complications at delivery or immediately after? Yes/No If yes, please explain: _____

Admitted to Regular nursery: Yes/No NICU: Yes/No

Does your child have any chronic illness such as asthma, seizures, diabetes, cancer, HIV, anemia, high lead levels, thyroid dysfunction, chronic motor and vocal tics? If so, please describe: _____

_____

Does your child take any medications? Yes/No If yes, please list: _____

Is there any past history of:

Surgery	Yes/No	Ear infections	Yes/No
Anesthesia	Yes/No	Headache/stomachache	Yes/No
Head trauma with change in mental status	Yes/No	Dizzy spells, fainting	Yes/No
Is your child up to date on immunizations	Yes/No	Chronic constipation	Yes /No
Hospitalizations	Yes/No	Seizures with fever	Yes/No
Has your child recently checked for hearing	Yes/No	Difficulty in chewing/swallowing	Yes/No
Has your child recently checked for vision	Yes/No	Growing on the growth curve	Yes/No

Developmental Milestones - Indicate age when child:

Sat _____ Crawled _____ Walked _____

Does child run/jump /climb? Yes/No Is child clumsy/falls often? Yes/No Rides a bike? Yes/No

Cut with scissors? Yes/No Hand writing sloppy? Yes/No

Age of first words _____ Age spoke 2-3 words together _____ Age spoke in sentences _____

Language spoken at home _____ Child's preferred language _____

Is the speech difficult to understand? Yes/No Does child respond to name? Yes/No

Does child use gestures or pointing to communicate? Yes/No Does child follow directions? Yes/No

Self-help Skills:

Does child feed himself: Yes/No Use a spoon/fingers: Yes/No Needs to be fed: Yes/No
Dresses by himself: Yes/No Bathes self: Yes/No Completes Homework: Yes/No

Child's Behavior:

Describe your child's behavior at home regarding activity level, attention span, listening skills and following directions:

_____

Describe your child's behavior in school /day care / after-school: _____

Does your child have difficulty in getting along with peers of his age, making friends or maintaining friendship?

_____

Family History:

Whom does the child currently reside with? _____

Relationship to the child: Mother _____ Father _____ Guardian _____ Other _____

Marital status: (circle one) Single Married Separated Divorced

Are both parents actively involved in the care and planning for this child? Yes/No

Are both parents in agreement with this evaluation? Yes/No

If no, please explain_____

Is there a custody battle? Yes/No If yes, please explain: _____

Has your child experienced any traumatic event such as child abuse /neglect / loss of loved one / witness to violence and trauma? Yes/No

If yes, please explain: _____

Family History of Educational, Medical and Psychiatric Illness

	Mother	**Father**
Age of parent:	_____	_____
Highest level of education achieved	_____	_____
Any childhood history of speech delay, developmental/ learning difficulties or behavior problems?	_____	_____
Neurological History: Seizures, involuntary movements, Multiple Sclerosis, Muscular Dystrophy	_____	_____
Tics/Tourette Syndrome	_____	_____
Cardiac illness / arrhythmia	_____	_____
Genetic disorder	_____	_____
Cerebral Palsy	_____	_____

Intellectual disability	_____	_____
Psychiatric history of:		
Depression	_____	_____
Anxiety	_____	_____
ADHD/ODD	_____	_____
OCD	_____	_____
Social deficits	_____	_____
Drug use/ Alcohol use	_____	_____

Please list any other family members with:	**Maternal Family**	**Paternal Family**
Learning disability	_____	_____
Cerebral Palsy	_____	_____
Autism	_____	_____
Seizures	_____	_____
Intellectual disability	_____	_____
Genetic disorder	_____	_____
ADD/ADHD	_____	_____
Depression	_____	_____
Anxiety/OCD	_____	_____
Alcoholism /Drug Use		

Other siblings:

Name: _____	Age: _____	Special Needs: _____
Name: _____	Age: _____	Special Needs: _____
Name: _____	Age: _____	Special Needs: _____

IMPORTANT:

1. **Information release: This office complies with HIPPA regulations of privacy practices.**

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2. **Please share all pertinent information with the physician to develop a comprehensive treatment plan. If there is any personal information that you would like to be excluded from the report, please remember to specify at the time of the visit.**

3. **A detailed report will be done after this evaluation. The report will only be released to the referral source. Please obtain a copy of the report from your child study team if they have referred your child.**

4. **We do not accept any insurance, but we will give you a bill that you should submit to your insurance.**

5. **We expect full payment at the time of service by check or cash. We do not accept credit or debit cards.**

I HAVE READ THE ABOVE INFORMATION.
I AGREE TO TAKE FULL RESPONSIBILITY AS DIRECTED.

Date: _____ **Signature:** _____