3350 W. Salt Creek Lane, Suite 115
Arlington Heights, IL 60005
224-248-9449 Fax: 847-394-9505

Registration Form

Name of Child (Full/Given): _____

Address: _____

City, State, Zip Code: _____

Home Phone: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Main Contact Email Address: _____

Contacts:

Name	Telephone Number	Relationship

Mother's Information:

Name: _____ Cell #: _____

Mother's Employer: _____

Occupation/Title: _____ Work Phone: _____

Father's Information

Name: _____ Cell #: _____

Father's Employer: _____

Occupation/Title: _____ Work Phone: _____

Siblings:

Name	Sex	Age	Any concerns about this child?
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

What do you hope you and your child will gain from this evaluation and/or therapy?

☐ I would like more information

☐ I would like an answer or diagnosis

☐ Other: _____

At what age did you first have concerns regarding your child's functioning? _____

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Please explain your concerns: _____

_____

_____

Has your child received any special services and/or therapeutic services in the past? ☐ Yes ☐ No

If yes, why? _____

_____

If yes please include:

Provider Name	Provider Phone Number	Service Received:	Date of Service

If any of these services were discontinued, please describe why: _____

_____

_____

Has your child had a formal hearing test? (Please provide date(s) of testing and results)

Date(s): _____ Results: _____

_____

Has your child had a formal vision test? (Please provide date(s) of testing and results)

Date(s): _____ Results: _____

_____

Does your child have any *diagnoses or identified disabilities (i.e. seizures, epilepsy, ADHD, Asthma)?

(If yes, please list below) ☐ Yes ☐ No

Diagnosis	Date Given	By Whom

Have you been told or do you feel that your child shows any characteristics of a diagnosis or disability?

If yes, please explain by whom: _____

_____

Who can we thank for referring you? _____

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CURRENT FUNCTIONAL SKILLS

Motor Skills:

Is your child: ☐ Athletic ☐ Average ☐ Uncoordinated

Does your child ever bump/run into objects? ☐ Yes ☐ No ☐ N/A

Does your child have difficulty with any of the following tasks? (Check all that apply) ☐ N/A

☐ Running ☐ Hopping ☐ Skipping ☐ Throwing ☐ Catching

Does your child enjoy coloring: _____ cutting: _____ pasting: _____ puzzles: _____

Does your child have a hand preference? Right Left Not at this time

Does your child have difficulty using utensils (i.e. cutting foods, spreading): ☐ Yes ☐ No

Does your child have any difficulty dressing himself/herself: ☐ Yes ☐ No

Social Skills:

	☐ Always	☐ Often	☐ Never	☐ N/A
Does your child have any difficulty playing with peers?	☐ Always	☐ Often	☐ Never	☐ N/A
Does your child prefer to play alone?	☐ Always	☐ Often	☐ Never	☐ N/A
Does your child prefer to play with children 1-2 yrs younger?	☐ Always	☐ Often	☐ Never	☐ N/A
Does your child have a short attention span?	☐ Always	☐ Often	☐ Never	☐ N/A
Does your child demonstrate self-stimulating behaviors?	☐ Always	☐ Often	☐ Never	☐ N/A

If yes, please identify: _____

Behavior and Temperament:

Please check all boxes that describe your child:

☐ Quiet ☐ Outgoing ☐ Anxious ☐ Intense ☐ Easily frustrated ☐ Aggressive

☐ Able to adjust easily to a change in routine

☐ Other: _____

Does your child have frequent tantrums? _____

Does your child display extreme mood changes? _____

Does your child demonstrate aggressive, acting out behavior? _____

Is your child rigid, set in his/her ways? _____

How well does your child adapt to a new situation and/or an unfamiliar person? _____

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EDUCATIONAL HISTORY

Current School: _____ Grade: _____

Does your child enjoy school: _____

Is your child receiving any special services at school? (If yes, by whom?) ☐ Yes ☐ No

_____

_____

Please describe any issues or challenges that your child faces during the school day: _____

_____

_____

What subjects or aspects of school are easiest/most enjoyable for your child? _____

_____

_____

What subjects or aspects of school are hardest/least enjoyable for your child? _____

_____

_____

Sensory:

Does your child prefer touch, rather then be touched? Have a strong need to touch objects and people?

_____

Does your child frequently bump or push others?

_____

Does your child dislike the feeling of certain clothing?

_____

Does your child seem overly sensitive to food or water temperature? Sensitive to particular smells or tastes?

_____

Does your child often seem unaware to cuts and/or bruises?

_____

Does your child walk on toes?

_____

Does your child lose balance easily? Appear clumsy or uncoordinated? Bump into things a lot?

_____

Does your child spin or whirl more than other children?

_____

Is your child easily distracted by sounds such as the refrigerator, fans and heaters?

_____

Does your child display an unusual sensitivity to light?

_____

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Social Skills:

Is your child able to play alone for a reasonable length of time?

Is your child destructive with toys?

Is your child more rigid in the way in which they play?

Does your child prefer to company of adults or older children?

Does your child prefer to play with children 1-2 years younger?

Does your child play in a cooperative manner with peers? Make friends easily?

Does your child take turns appropriately? Share appropriately?

Does your child follow through with responsibilities?

Does your child express feeling of low self-esteem? Feelings of failure and frustration? Seem discouraged or depressed?

Additional Comments:

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PERSONALITY PROFILE

What are your child's gifts/strengths? _____

What do you enjoy most about your child and family? _____

What are the presenting problems for your child? (All categories below may not apply)

Academic: _____

Activities of daily life (eg. Eating, dressing): _____

DEVELOPMENTAL MILESTONES

(Give approximate ages if remembered, or comment on anything unusual)

Say words _____ Rolling over _____
Chew solid foods _____ Walk _____
Say sentences _____ Sit alone _____
Drink from cup _____ Crawl _____

Was crawling phase brief? ☐ Yes ☐ No Absent? ☐ Yes ☐ No

Did child use a walker (rolling plastic seat)? ☐ Yes ☐ No If yes, how often? _____

Experience hesitancy or delays in learning to go down stairs? ☐ Yes ☐ No

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MEDICATIONS

List any medications your child has received **in the past**:

Medication: _____ Purpose: _____
When taken: _____
Medication: _____ Purpose: _____
When taken: _____
Medication: _____ Purpose: _____
When taken: _____
Medication: _____ Purpose: _____
When taken: _____

List any medications your child is **currently taking**:

Medication: _____ Purpose: _____
When taken: _____
Medication: _____ Purpose: _____
When taken: _____
Medication: _____ Purpose: _____
When taken: _____
Medication: _____ Purpose: _____
When taken: _____

PREGNANCY (If child is adopted, skip to Adoption Section)

What kind of experience was the pregnancy for both mother and father?

Father: _____

_____

Mother: _____

_____

Was it planned?	☐ Yes	☐ No
Were there complications?	☐ Yes	☐ No
shock	☐ Yes	☐ No
severe stress	☐ Yes	☐ No
loss of a loved one (accident)	☐ Yes	☐ No
health problems, specify confinement to bed	☐ Yes	☐ No _____
other: _____	☐ Yes	☐ No
was mother exposed to loud noises?	☐ Yes	☐ No
did mother smoke?	☐ Yes	☐ No
did mother consume alcohol?	☐ Yes	☐ No
did mother take any medication? (specify)	☐ Yes	☐ No _____
did mother talk much?	☐ Yes	☐ No
was mother physically active?	☐ Yes	☐ No
were any previous pregnancies complicated?	☐ Yes	☐ No

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LABOR AND DELIVERY

Describe your experience during labor and delivery: _____

_____

_____

			Comments
Length of labor	☐ Yes	☐ No	_____
Premature: specify	☐ Yes	☐ No	_____
Forceps used	☐ Yes	☐ No	_____
High forceps	☐ Yes	☐ No	_____
Required Suction	☐ Yes	☐ No	_____
Delivery position (breech)	☐ Yes	☐ No	_____
Caesarean birth (reason)	☐ Yes	☐ No	_____
Birth weight	☐ Yes	☐ No	_____
APGAR ratings (if known)	☐ Yes	☐ No	_____
Cried immediately	☐ Yes	☐ No	_____
Required special treatment	☐ Yes	☐ No	_____
(ie: required oxygen, had jaundice, etc)	☐ Yes	☐ No	_____
Birth injuries: specify	☐ Yes	☐ No	_____
Did the newborn have immediate physical contact with the mother?	☐ Yes	☐ No	_____
Was there a positive bonding experience between mother and newborn at birth?	☐ Yes	☐ No	_____

Describe any separates from mother during first days of life: _____

_____

_____

Did mother experience any post-partum depression? ☐ Yes ☐ No _____

ADOPTION

Describe the circumstances surrounding the adoption:

_____

_____

_____

More specifically:

Age when adopted _____

Prior foster homes: _____

Physical appearance: _____

Response to new home: _____

Is your child aware of his/her adoption? _____

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SPEECH AND LANGUAGE DEVELOPMENT

How would you describe your child's speech and language development?

Normal _____ Delayed _____ Advanced _____

Did your child begin speaking in single words, then two, then a sentence? ☐ Yes ☐ No

Did your child not talk for a long while, then all of a sudden speak in a complete sentences?

_____

Do you or others have difficulty understanding what your child says? ☐ Yes ☐ No

First words and at what age: _____

Describe any speech related problems: _____

_____

AUDITORY DEVELOPMENT

Has your child experienced any problems with his/her hearing? (operations, infections, tubes)

_____

_____

_____

Ear infections? seldom ____ sometimes ____ often ____ mild ____ moderate ____ severe ____

Are there any current hearing problems of which you are aware?

_____

_____

Which language(s) is spoken at home?

_____

EDUCATION

How does your child adapt to the first day(s) at school or pre-school:

Mostly positive _____ Mixed _____ Mostly negative _____

How old was he/she? _____ How much time did he/she attend per week? _____

In general, how would you describe your child's experience/learning at school from kindergarten to the present time?

_____

_____

_____

_____

_____

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Please give us more detailed information about any difficulties your child encountered in school beginning with the earliest experience:

Initial school adjustment: _____

Pre-School/Daycare: _____

Primary (K - Grade 3): _____

Junior (Grade 4-Grade 6): _____

Intermediate (Gr. 7 - Gr 8): _____

High School (Gr. 9-Gr. 12) _____

Has there been remedial help given inside the school system? ☐ Yes ☐ No
If yes, describe: _____

GOALS:
What are your goals for your child's program? Please be as specific as possible:

1 _____

2 _____

3 _____

4 _____

5 _____