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## Admissions Packet

### Client General Information

Name: \_\_\_\_\_ Sex:    M / F   

Date Of Birth: \_\_\_\_\_

Phone Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Address (#1): \_\_\_\_\_

Address (#2): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

School: \_\_\_\_\_ Grade in School: \_\_\_\_\_

Teacher/s Name: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

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

How did you hear about us? \_\_\_\_\_

Emergency Contact (name & number): \_\_\_\_\_  
 (person you give permission to leave a message with in case of an accident or a therapist emergency)

### Service Providers

<u>Service</u>	<u>Provider</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Parent / Legal Guardian Information**

Mother

Father

Name: \_\_\_\_\_

\_\_\_\_\_

Address:  
(if different than child's):  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Number: \_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Number: \_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

\_\_\_\_\_

Age at birth of Child: \_\_\_\_\_

\_\_\_\_\_

Overall Health: \_\_\_\_\_

\_\_\_\_\_

Marital Status: \_\_\_\_\_

\_\_\_\_\_

Education: \_\_\_\_\_

\_\_\_\_\_

Occupation: \_\_\_\_\_

\_\_\_\_\_

Other individuals living in the home consistently:

Name

Age

Relationship to the Child

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

## Pregnancy History

This child is:

- A natural child
- An adopted child with no previous medical history available
- An adopted child with medical history available

This child was the product of the \_\_\_\_ pregnancy.

The mother miscarried \_\_\_\_ times prior to this pregnancy.

Out of the \_\_\_\_ pregnancies carried to term prior to this one, there were \_\_\_\_ livebirths and \_\_\_\_ stillbirths.

This child has \_\_\_\_ siblings older than him/her.

Complications experienced by the mother while pregnant with this child included:

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While the mother was pregnant, the parents:

	<u>Mother</u>	<u>Father</u>
Smoked regularly	<input type="checkbox"/>	<input type="checkbox"/>
Smoked occasionally	<input type="checkbox"/>	<input type="checkbox"/>
Had two or more drinks daily	<input type="checkbox"/>	<input type="checkbox"/>
Used illegal drugs regularly	<input type="checkbox"/>	<input type="checkbox"/>

## **Birth History**

Length of Pregnancy: \_\_\_\_\_ Weight at Birth: \_\_\_\_\_ Length: \_\_\_\_\_

Labor had to be induced because of: \_\_\_\_\_

Complications during labor included: \_\_\_\_\_

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Any indications of difficulties at birth? Please explain: \_\_\_\_\_

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Child was in intensive care because of: \_\_\_\_\_

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Child was in intensive care for \_\_\_\_\_ days.

Length of stay in hospital: \_\_\_\_\_

## Developmental History

When were your child's difficulties first noted?

\_\_\_\_\_

Please describe those difficulties:

\_\_\_\_\_  
\_\_\_\_\_

Who was the first person to notice these difficulties? \_\_\_\_\_

Complications during development included:

Seizures                       High fever                       Feeding difficulties                       Sleep disturbances

Allergies                       Serious illness                       Chronic ear infection                       Genetic disorder

Other: \_\_\_\_\_

Please provide your child's age, to the best of your memory, of when he/she accomplished the following:

Roll over: \_\_\_\_\_                      Reach for objects: \_\_\_\_\_

Sit alone: \_\_\_\_\_                      Crawl: \_\_\_\_\_

Walk alone: \_\_\_\_\_                      First words: \_\_\_\_\_

Finger feed: \_\_\_\_\_                      Fed self with spoon: \_\_\_\_\_

Scribble: \_\_\_\_\_                      Toilet train: \_\_\_\_\_

List of serious illness or hospitalizations and date:

<u>Illness</u>	<u>Date</u>	<u>Length of Stay</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any medication/supplements your child has taken or is taking regularly:

<u>Medication</u>	<u>Reason for it</u>	<u>Prescribed by</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Child's Current Behavior**

What types of activities do you/your spouse enjoy doing with your child?

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Describe a typical day with your child.

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Please describe your child's strengths:

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Please describe your child's difficulties:

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Please list areas where you would like to observe improvements with your child:

Within the next three months:

Within the next year:

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Please list the behaviors you would like to see increased and those you would like to see decreased:

Increased

Decreased

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