154 So. Livingston Avenue · Suite 204
Livingston · NJ 07039 · (973) 535-5010
www.pediatricpotentialsnj.com

# New Family Registration Form

OT or PT Therapist Name: _____ Date _____

Child's First & Last name: _____ Nickname:_____

Child's Date of Birth: _____ Age: _____ Male ☐ / Female ☐

Home Address: _____

City/State/Zip: _____

1. Parent 1 Name: _____ Occupation: _____

Phone: (H)_____ (Cell) _____

Email: _____

2. Parent 2 Name: _____ Occupation: _____

Phone: (H)_____ (Cell) _____

Email: _____

**EMERGENCY NOTIFICATION***: If you will be leaving your child during the session, please ensure your therapist has a way to reach you in the event of an unlikely emergency (Cell phone and destination). Person(s) who may be accompanying your child to therapy if not a parent:*

Name _____(relation to child) Phone_____

Any siblings? names and ages _____Insurance Provider:_____

Who referred you to us? _____ Phone: _____

Reason for the referral: _____

Pediatrician Name: _____ Phone: _____

Form completed by :_____ Relation: _____

## Medical History and Medications

Brief Medical history (hospitalizations, surgery, existing conditions or prior diagnoses)

_____

Medications: _____

**ALLERGY ALERT** Are there any food allergies, seizures, medications or medical conditions which might affect your child's ability to participate in testing or therapy activities? If yes, please describe and provide emergency information. (e.g. epi pen, seizure precautions, inhalers, latex allergies, profound carsickness, etc.)

_____

Does your child require glasses, hearing aid, special shoe inserts, etc.?

_____

Describe your impressions of your child's strengths and weaknesses

_____

_____

Child's school: _____ Teacher: _____

School hours: _____ Grade:_____

Has your child received therapy services at any time?
(circle all that apply) OT PT Speech DI counseling other

If yes, please describe goals and outcomes

_____

_____

Are there any recent events that may be impacting on your child? (e.g. divorce, death, separation, new baby, move, serious illness, hospitalization, etc.)?

_____

# DEVELOPMENTAL MILESTONES

Describe any problems accompanying your pregnancy, delivery or neonatal period of time.

_____

Is your child adopted? No Yes If yes, does your child know about his heritage? Do you have knowledge regarding your child's birth history? _____

_____

Indicate approximate ages by which the following developmental milestones were reached. Describe any unusual aspects of your child's development:

* Crawling _____ * Sitting unsupported _____ * Walking _____

* Talking (mama, papa) _____ * Talking (short sentences) _____

* Toilet training _____

* First school experiences – Comments: _____
_____

* Present school experiences – Comments: _____
_____

Describe your child's general behavior at home related to moods, independence, transitions, engagement, responsiveness, frustration, management and response to discipline, etc.:
_____

_____

Describe your child's play time activities, including toys he/she prefers or avoids:
_____

_____

## SENSORY OBSERVATIONS

Does your child react adversely to (circle all that apply)

touch smell movement heights clothing

Does your child have any difficulty with any of the following?

| | NO | Sometimes | YES | | NO | Sometimes | YES |
|---|---|---|---|---|---|---|---|
| **Tolerating noises** | | | | **Following several instructions** | | | |
| **Tolerating light** | | | | **Trying/learning new games** | | | |
| **Sleeping** | | | | **Novel foods** | | | |
| **tolerating clothing** | | | | **Separation from parents** | | | |
| **Baths/hair wash** | | | | **Being in a crowd** | | | |
| **Swimming** | | | | **Tantrums** | | | |
| **Stairs** | | | | **Transitions** | | | |
| **Bike ride** | | | | **Playing with same age kids** | | | |
| | | | | | | | |

If *Sometimes* or *YES* describe briefly: (*use back if needed*)

_____

_____

Describe what you hope your child will accomplish in an occupational or physical therapy program.

_____

_____

Please add any comments or descriptions which will help us to better understand your child and your concerns for your child (*use back if needed*):

_____

_____