



Registration/ Contact Information

I would like to learn more about:

- | | |
|---|--|
| <input type="checkbox"/> Treatment/ Services | <input type="checkbox"/> Listening Therapy (Berard AIT, Integrated Listening Systems (ILs), The Listening Program (TLP)) |
| <input type="checkbox"/> Evaluation | <input type="checkbox"/> Interactive Metronome |
| <input type="checkbox"/> General Program Information | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> SIPT/ Sensory Integration & Praxis Test | <input type="checkbox"/> Therapy Intensive Programs |
| <input type="checkbox"/> Groups (Social Skills, Alert Program, Sensory Motor) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Feeding Therapy | |

I am a:

- | | |
|---|---|
| <input type="checkbox"/> Parent | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Other Professional |
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Other: _____ |

My name is:

1. _____
(First) (Last)

Address: _____

Phone: (H) _____ **(C)** _____
(W) _____

Email: _____ **Fax:** _____

The best time to reach me is (Circle all that apply):

Morning Afternoon Evening

The best way to contact me is (Circle all that apply):

Home phone Work phone Cell phone Email Other: _____

I am interested in placing a child on the reservation/waiting list:

- | | |
|--|---|
| <input type="checkbox"/> Yes! Please contact me to reserve the first available appointment. | <input type="checkbox"/> No. Not ready to make a reservation at this time. |
|--|---|



Child's Information (Please complete all fields that apply)

Child's Name: _____

Date of Birth: ____ / ____ / ____ Age ____ Male ____ Female ____

School: _____ Grade: _____

Parents Names: _____

Address: _____

Telephone # (H) _____ (W) _____ (Cell) _____

Pediatrician: _____ Phone: _____

Specialist/s: _____ Phone: _____

_____ Phone: _____

_____ Phone: _____

Diagnosis: _____

List Current Concerns/ Presenting Problems: _____

List Specific Goals of Evaluation/ Treatment: _____

List Current/ Previous Treatment if known & where: _____

List Previous Evaluation/s (Professional/Center/Date): *Please provide copies of most recent evaluations if available.*

OT _____

Psychological _____

Educational _____

Other: _____

Additional Comments/ Question: _____

Preferred Method of Payment (circle): **Cash** **Check** **Insurance** **Other**



Check Any of the Following That May Apply to the Child:

<input type="checkbox"/>	Developmental Delay	<input type="checkbox"/>	Sleep Disturbance	<input type="checkbox"/>	Auditory processing delays
<input type="checkbox"/>	Learning Disability	<input type="checkbox"/>	Sensory Sensitivities	<input type="checkbox"/>	Listening challenges
<input type="checkbox"/>	ADHD/ADD/ Attention Deficit	<input type="checkbox"/>	Sensory Seeker	<input type="checkbox"/>	Difficulty following directions
<input type="checkbox"/>	Autism Spectrum	<input type="checkbox"/>	Picky Eater	<input type="checkbox"/>	Chronic Ear Infections
<input type="checkbox"/>	PDD	<input type="checkbox"/>	Gravitational Insecurity	<input type="checkbox"/>	Sound Sensitivity
<input type="checkbox"/>	Aspergers	<input type="checkbox"/>	DCC/ Developmental Coordination Disorder	<input type="checkbox"/>	Coordination challenges/ clumsy
<input type="checkbox"/>	Prematurity	<input type="checkbox"/>	Writing challenges	<input type="checkbox"/>	Balance challenges
<input type="checkbox"/>	Brain Trauma	<input type="checkbox"/>	Reading challenges	<input type="checkbox"/>	Attention challenges
<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	Cognitive Delay	<input type="checkbox"/>	High activity level
<input type="checkbox"/>	Fetal Alcohol Syndrome	<input type="checkbox"/>	MR/ Mental Retardation	<input type="checkbox"/>	Low activity level
<input type="checkbox"/>	Academic challenges	<input type="checkbox"/>	Multiple Disabilities	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Behavior challenges	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Social challenges	<input type="checkbox"/>	Spina Bifida	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Sensory Processing Disorder	<input type="checkbox"/>	Down Syndrome	<input type="checkbox"/>	Other: _____



List any significant Prenatal or Birth History (Weeks gestation; birth weight; head circumference; APGARS):

- | | | |
|---|---|---|
| <input type="checkbox"/> Premature | <input type="checkbox"/> Emergency C-section | <input type="checkbox"/> Bottle fed |
| <input type="checkbox"/> Full term | <input type="checkbox"/> Vaginal Birth | <input type="checkbox"/> Multiple Ultrasounds |
| <input type="checkbox"/> Low birth weight | <input type="checkbox"/> Forceps Delivery | <input type="checkbox"/> Oxygen at Birth |
| <input type="checkbox"/> IUGR | <input type="checkbox"/> Vacuum Delivery | <input type="checkbox"/> NICU stay |
| <input type="checkbox"/> Weeks Gestation | <input type="checkbox"/> Preeclampsia | <input type="checkbox"/> Duration in NICU _____ |
| <input type="checkbox"/> Breech Birth | <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> C-section Birth
(planned) | <input type="checkbox"/> Breast fed | |
| | <input type="checkbox"/> Poor suction/latch | |

List any significant Medical History (chronic ear infections/ tubes/ reflux/ surgeries, illness, hospitalization, etc...):

- | | | |
|---|--|--|
| <input type="checkbox"/> Chronic ear infections | <input type="checkbox"/> Colic | <input type="checkbox"/> Frequent fevers |
| <input type="checkbox"/> Tubes | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Compromised immune system |
| <input type="checkbox"/> Tonsils/Adenoid Surgery | <input type="checkbox"/> Asthma | <input type="checkbox"/> Abnormal Lab results |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Allergies | <input type="checkbox"/> Cardiac Issues |
| <input type="checkbox"/> Surgeries: <u>list above</u> | <input type="checkbox"/> Abnormal muscle tone | <input type="checkbox"/> Lyme Disease |
| <input type="checkbox"/> Poor weight gain | <input type="checkbox"/> Torticollis | <input type="checkbox"/> Other: <u>list above</u> |
| | <input type="checkbox"/> Frequent antibiotic use | |

My child...(Fill in the blanks and check the appropriate boxes that describe your child)

- Had his/ her hearing tested at ___months/years
 Had his/her vision tested at ___months/years
 Has normal hearing
 Has normal vision
 Has hearing loss
 Has a vision deficit
 Wears Glasses
 Is on the following medications _____

List any medical conditions, allergies, or precautions that are known: _____

Medical Diagnosis: _____



Developmental History

My child... (Fill in the blanks and check appropriate boxes that describe your child)

- Sat at _____ months/years
- Crawled at _____ months/years
- Stood at _____ months/years
- Walked at _____ months/ years
- Talked at _____ months/ years
- Dressed at _____ months/ years
- Toilet trained at _____ months/ years
- Fed self _____ months/years

- Was placed on his/her belly as an infant
- Was not placed on his/her belly as an infant
- Enjoyed belly time as an infant
- Did not tolerate being placed on his/her belly as an infant
- Met all motor milestones on time
- Was/is developmentally delayed
- Was late to _____
- Is good with his/her hands (fine motor skills)
- Is good negotiating playground equipment
- Is athletic/ plays sports
- Plays the following sports _____
- Is enrolled in dance, ballet, gymnastics, and/or tap dancing
- Is enrolled in karate
- Is clumsy
- Avoids climbing, swinging, sliding

List any motor development concerns (gross motor, fine motor, oral motor, motor planning, clumsy, fear of movement, fear of heights, etc): _____

Academic/ Educational History

My child... (Fill in the blanks and check appropriate boxes that describe your child)

- Does well in school
- Does well with the exception of _____
- Is challenged by school
- Is challenged by writing
- Is challenged by reading
- Is not enrolled in school
- Receives resource/ tutoring for: _____
- Is an A B C D F Student
- Is in a self-contained classroom



List any academic/school concerns: _____

List specific teacher concerns: _____

Behavior/ Social History

My child... (Check appropriate boxes that describe your child)

- | | |
|---|---|
| <input type="checkbox"/> Is social and engaging | <input type="checkbox"/> Quickly escalates without apparent cause |
| <input type="checkbox"/> Makes good eye contact with adults and peers | <input type="checkbox"/> Extremely sensitive to criticism |
| <input type="checkbox"/> Is well behaved | <input type="checkbox"/> Unable to self-calm |
| <input type="checkbox"/> Pays attention | <input type="checkbox"/> Poor coping skills |
| <input type="checkbox"/> Listens well | <input type="checkbox"/> Is very busy and active |
| <input type="checkbox"/> Follows directions well | <input type="checkbox"/> Has difficulty paying attention |
| <input type="checkbox"/> Plays well with other children | <input type="checkbox"/> Has difficulty listening |
| <input type="checkbox"/> Is easy going | <input type="checkbox"/> Has difficulty following directions |
| <input type="checkbox"/> Does well with change | <input type="checkbox"/> Prefers to play alone |
| <input type="checkbox"/> Understands safety | <input type="checkbox"/> Has difficulty with transitions |
| <input type="checkbox"/> Takes turns with peers | <input type="checkbox"/> Is ritualistic with play |
| <input type="checkbox"/> Is aggressive | <input type="checkbox"/> Does not like crowds |
| <input type="checkbox"/> Is oppositional | <input type="checkbox"/> Does not like new places/ people |
| <input type="checkbox"/> Has tantrums | |

List any behavior/ social concerns: _____

Sensory History

My child... (Check appropriate boxes that describe your child)

- | | |
|---|--|
| <input type="checkbox"/> Is sensitive to sound | <input type="checkbox"/> Avoids a certain taste (salty, sweet, sour, spicy, bland) |
| <input type="checkbox"/> Is sensitive to light | <input type="checkbox"/> Is a picky eater |
| <input type="checkbox"/> Is distracted by busy environments | <input type="checkbox"/> Avoids certain smells |
| <input type="checkbox"/> Avoids crowds | <input type="checkbox"/> Avoids heights |
| <input type="checkbox"/> Gets upset or withdraws from loud noises | <input type="checkbox"/> Avoids movement activities |
| <input type="checkbox"/> Fixates on spinning objects | <input type="checkbox"/> Avoids playground equipment |
| <input type="checkbox"/> Fixates on shiny objects | <input type="checkbox"/> Avoids slides |
| <input type="checkbox"/> Avoids touching objects or textures | <input type="checkbox"/> Avoids swings |
| <input type="checkbox"/> Is sensitive to clothing tags | <input type="checkbox"/> Is clumsy |
| <input type="checkbox"/> Is sensitive to seams in clothing or socks | <input type="checkbox"/> Gets dizzy easily |
| <input type="checkbox"/> Avoids a certain texture food (crunchy, mushy, mixed, chewy) | <input type="checkbox"/> Has poor balance |
| | <input type="checkbox"/> Has poor sense of body and self |

THERAPEDIATRICS, Inc.



Therapy That Makes Sense

P.O. Box 740- Saunderstown, RI 02874

(401) 284-4357/ (401) 284-4358 (fax)

- | | |
|---|--|
| <input type="checkbox"/> Enjoys the playground | <input type="checkbox"/> Wanders without direction |
| <input type="checkbox"/> Enjoys rough and tumble play | <input type="checkbox"/> Has difficulty planning activities |
| <input type="checkbox"/> Is a good eater | <input type="checkbox"/> Has difficulty listening and following directions |
| <input type="checkbox"/> Enjoys a variety of textured foods | <input type="checkbox"/> Is difficult to understand |
| <input type="checkbox"/> Overstuffs when eating and/ or pockets foods | <input type="checkbox"/> Has language delays |
| <input type="checkbox"/> Seeks out excessive movement throughout the day | <input type="checkbox"/> Has poor posture |
| <input type="checkbox"/> Can't sit still | <input type="checkbox"/> Appears weaker than other children his/ her age |
| <input type="checkbox"/> Difficulty regulating states of arousal/ activity level | <input type="checkbox"/> Is athletic |
| <input type="checkbox"/> Doesn't seem to register pain | <input type="checkbox"/> Is coordinated |
| <input type="checkbox"/> Doesn't seem to notice temperature extremes | <input type="checkbox"/> Enjoys multi-sensory play activities (lights, sounds, textures, movement) |
| <input type="checkbox"/> Enjoys a variety of textures play activities | <input type="checkbox"/> Is a visual learner |
| <input type="checkbox"/> Likes to play in the bath | <input type="checkbox"/> Is a hands-on learner |
| <input type="checkbox"/> Enjoys swimming or water play | <input type="checkbox"/> Gets motion sickness |
| <input type="checkbox"/> Likes messy play | <input type="checkbox"/> Gets easily over-stimulated by busy environments |
| <input type="checkbox"/> Likes to play with his/ her food | <input type="checkbox"/> Is a sound sleeper |
| <input type="checkbox"/> Eats sticky/messy food with fingers (French toast sticks with syrup, French fries with ketchup, peanut butter and jelly, etc...) | <input type="checkbox"/> Has sleep disturbances |
| | <input type="checkbox"/> Falls to sleep easily |
| | <input type="checkbox"/> Has difficulty falling asleep |
| | <input type="checkbox"/> Does best with structure and routine |

List any sensory concerns: _____

Evaluation and Therapy Service

List any previous occupational therapy evaluations completed and recommendations: _____

List any previous psychological/ neuropsychological/ psych-educational evaluations completed and recommendations: _____

List all past/ current therapy services: _____

List all past/ current educational services: _____

THERAPEDIATRICS, Inc.



Therapy That Makes Sense

P.O. Box 740- Saunderstown, RI 02874

(401) 284-4357/ (401) 284-4358 (fax)

List specific testing or service needs if known: _____

Please list all concerns and questions you would like answered as a result of this consultation/ evaluation: _____

List any specific service or program you are interested in: _____

Preferred Appointment days/times: _____

List Referral Source (How did you find out about us?): _____

Method of Payment

Preferred Method of Payment:

Cash

Check

Insurance (BCBS)

Insurance Company Name: _____

Street: _____

City: _____ *State:* _____ *Zip:* _____

Contact: _____ *Phone:* _____

Subscriber Name: _____

Policy #/ S.S#: _____

Agency/ School: _____

Other: _____

We are currently a provider for BCBS only



Instructions/ Additional Information

- Complete Registration Form Online
- Complete Intake Form Included
- Sign appropriate release forms so we may contact your child's physician, teacher, therapist(s), and/or other healthcare professional to gain more information pertaining to your child's development.

_____ Primary Care Physician/ Pediatrician
_____ Specialists
_____ Occupational Therapist
_____ Psychologist
_____ Teacher/ Educator
_____ Daycare
_____ Agency
_____ Tutor
_____ Other

- Forward copies of any relevant evaluations completed in the past 3 years.
- Forward doctor/ pediatrician script for occupational therapy evaluation and therapy services (We can get started with a consultation/evaluation; **However, therapy services can not begin without a signed and dated doctor prescription**). You may bring this with you to the first appointment.
- Mail forms to:

THERAPEDIATRICS, INC.
P.O. BOX 740
SAUNDERSTOWN, RI 02874

- Once received, you will be contacted to schedule an appointment. Please specify days/times your child will be available, as we try to accommodate busy schedules to the best of our ability. For example, if your child is in school specify "After school hours (anytime after 3pm) Monday through Friday".