 Registration

Mailing Address

Powerhouse Therapy

4650 Glenforest Dr. NE

Roswell, GA 30075

1. IDENTIFYING INFORMATION OF INDIVIDUAL REFERRED TO CLINIC

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Middle Nickname

Involved Side: \_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Sex: \_\_\_M \_\_\_\_F

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

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Family Information:

 Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Child’s Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other than parents, who lives in the household?

Name Age

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Names of Individuals that Child can be released to:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you first notice that your child had any difficulties with development?

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Has your child ever been given a medical, developmental, psychological, language, motor, or other diagnosis? If so, what was the diagnosis and who made it?

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Have you currently or in the past been followed by therapy or other specialist?

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How would you describe your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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III. Medical History:

Surgeries: Yes \_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_

Date Type Reason

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If child is currently taking medications, please list below:

Type of Medication Dose Reason

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Does your child have allergies? Yes \_\_\_\_\_ No \_\_\_\_\_ Epipen \_\_\_\_\_\_\_\_\_\_\_

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please answer the following about the child:

Seizures: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep problems: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision problems: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Glasses: Yes \_\_\_\_\_ No \_\_\_\_\_

Hearing problems: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Feeding problems: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Current Developmental Information

**Please circle your child’s current level of functioning**

1. Feeding
2. Had difficulty sucking and swallowing
3. Is breast fed
4. Drinks from a bottle
5. Holds own bottle
6. Weaned
7. Drinks form cup with help
8. Drinks from cup by him/herself
9. Is fed by and adult
10. Is able to feed self cracker or other finger foods
11. Can feed self except for filling the spoon
12. Feeds self completely

Diet consists of (a.) strained (b) junior (c) table foods (d) special formula

Able to chew foods: Yes \_\_\_\_\_ No \_\_\_\_\_

Describe special problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 B. Motor Activity

 1. Can hold head up without support

 2. Can sit with support

 3. Can sit alone, without support

 4. Rolls over: (a) front to back (b) back to front

 5. Crawls: (a) pulls with arms (b) on hands and knees

 6. Can walk around furniture

 7. Can walk alone

 8. When walking frequently stumbles or falls

 9. Can run and jump

 10. Participates willingly in activities such as rolling a ball, singing songs.

 11. Hand preference: Right \_\_\_\_\_\_ Left \_\_\_\_\_\_ Both \_\_\_\_\_\_Not sure \_\_\_\_\_\_

 If your child has difficulty with coloring, fastening or handwriting,

 Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Toilet Training
2. In diapers
3. In training pants
4. Will go to toilet when taken by an adult
5. Goes by self when reminded
6. Goes by self with occasional accidents
7. Completely trained except for accidents at night
8. Bowel, but not bladder trained
9. Bladder, but not bowel trained
10. Completely bowel and bladder trained
11. Uses: (a) potty chair (b) small seat on big toilet (c) regular toilet seat

Describe special problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Communication – Child communicates mainly through use of:
2. Grunts
3. Gestures and/or pointing
4. Babbling
5. Single words
6. Phrases
7. Sentences
8. Sign Language
9. Picture Communication Boards/Schedules
10. Eye Pointing/eye gaze
11. Electronic talking devices
12. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Dressing
2. Does not dress or undress self or help with dressing.
3. Can remove some clothing (socks, shoes, pants).
4. Assists with dressing (holds arms out for shirt, lifts leg for pants).
5. Puts on some clothing.
6. Dresses self but needs help in buttoning, fasteners, tying.

 Do you have concerns about your child’s dressing skills?

 Yes \_\_\_\_ No \_\_\_\_

 If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Social Behavior
2. Does not respond to people or things around him/her.
3. Shows some awareness of people and objects (smiles, laughs).
4. Will respond to simple games (peek-a-boo, pat-a-cake).
5. Plays by self with simple toys.
6. Parallel play (will play alongside other children but does not play with them.
7. Plays simple games with other children (such as ring-around-rosie).
8. Enjoys pretend play (feed the doll, comb hair, talk on phone, etc).

Do you have any concerns about your child’s social skills or play skills? Yes \_\_\_\_ No \_\_\_\_

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What does your child like to do? (what toys does he/she like, what food does he/she like to eat, what makes him/her happy?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Behavior Problems
2. Does not obey commands.
3. Frequent tantrums and/or crying.
4. Withdrawal (avoids social contact, shy, timid).
5. Frequent hitting, kicking, biting, spitting.
6. Self-injurious behavior (such as head-banging, scratching).
7. Unusual behavior (such as rocking, spinning, finger-movements, other activity).

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 What do you do when your child misbehaves? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Education/Therapy

What school does your child attend? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of classroom: Preschool \_\_\_\_\_\_\_\_\_\_\_\_ Regular classroom \_\_\_\_\_\_\_\_\_\_\_

 Special needs class or combo with regular: \_\_\_\_\_\_\_\_

Does your child receive any special services at school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Does your child use any special equipment? Check all that apply:

\_\_\_Leg Braces \_\_\_Scoliosis Jacket \_\_\_Splints \_\_\_Walker \_\_\_Canes

 \_\_\_Crutches \_\_\_Parapodium \_\_\_Wheelchair \_\_\_Travel Chair

Please describe the major concerns you have about your child. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please describe your child’s movement abilities with his/her involved arm.

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**Preregistration phone consult required prior to registering: 404-933-9869**

Program Session: Please indicate 1st and 2nd choice

**\_\_\_\_\_Session 1 June 1st-26th, 2020**

 **This is a 4-week program: 3 weeks of CIMT followed by 1 week of Bimanual therapy.**

 **Location: Johns Creek, GA**

 **Timings: Morning: 8:30am-11:30am**

 **Afternoon: 12pm-3pm**

**\_\_\_\_\_Session 2 July 6th-24th, 2020**

**This is a 3-week CIMT program**

**Location: Roswell, GA**

**Timings: 8:30am-11:30am**

**\_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Mail Registration with $1,050 (includes $50 non-refundable application fee and $1,000 deposit which will be applied to your child’s tuition) to Powerhouse Therapy.

Deposit can be paid by check to Powerhouse Therapy or we will send you a paypal link to pay by credit card. The deposit is required to ensure your child’s spot in our program.