Registration
Mailing Address
Powerhouse Therapy
4650 Glenforest Dr. NE
Roswell, GA 30075

I. 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: _____

II. Family Information:

Home Address: _____
City _____State_____ Zip Code_____

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?

_____

_____

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?

_____

_____

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

_____

_____

_____

_____

How would you describe your child? _____

_____

_____

III. Medical History:

Surgeries: Yes _____ No _____

Date Type Reason

_____

_____

_____

If child is currently taking medications, please list below:

Type of Medication Dose Reason

_____
_____
_____

Does your child have allergies? Yes _____ No _____ Epipen _____
If yes, please explain: _____
_____

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 _____

IV. Current Developmental Information

Please circle your child's current level of functioning

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

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: _____
    _____
    _____

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

Describe special problems: _____
_____

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

D. Dressing
   1. Does not dress or undress self or help with dressing.
   2. Can remove some clothing (socks, shoes, pants).
   3. Assists with dressing (holds arms out for shirt, lifts leg for pants).

4. Puts on some clothing.
5. 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: _____
_____
_____

E. Social Behavior
1. Does not respond to people or things around him/her.
2. Shows some awareness of people and objects (smiles, laughs).
3. Will respond to simple games (peek-a-boo, pat-a-cake).
4. Child Plays by him/herself with simple toys.
5. Parallel play (will play alongside other children but does not play with them.
6. Plays simple games with other children (such as ring-around-rosie).
7. 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: _____
_____
_____

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?)
_____
_____
_____
_____

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

Describe: _____
_____

What do you do when your child misbehaves?_____
_____

G. 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. _____
_____
_____
_____
_____

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

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

Program Session: Please indicate 1st and 2nd choice

_____Session 1 Wed June 2nd-Wed June 30th, 2021
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 5th-23rd, 2021
This is a 3-week CIMT program
Location: Roswell, GA
Timings: 8:30am-11:30am

_____Session 3 June 7th-25th, 2021
This is a 3-week Lower Extremity CIMT program
Location: Johns Creek, GA
Timings: 12:00pm-3:00pm

_____Other: 2-week brush-ups and 2-week CIMT followed by 1-week bilateral available upon parent request and availability. Dates: TBD_____

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, Venmo, HSA, or we will send you a paypal link to pay by credit card (with added processing fee). The deposit is required to ensure your child's spot in our program.