



Registration
Mailing Address
Powerhouse Therapy
4650 Glenforest Dr.
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: _____

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 from cup with help
 7. Drinks from cup by him/herself
 8. Is fed by an 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. Plays by self 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 June 3rd-28th, 2019**
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 8th-26th, 2019**
This is a 3 week CIMT program
Location: Roswell, GA
Timings: 8:30am-11:30am

_____ **Other:** _____

Mail Registration with \$1,030 (includes \$30 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.