



REGISTRATION FORM

PLEASE MAIL TO: Powerhouse Therapy, 1525 Haven Crest Drive, Powder Springs, GA 30127

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

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 and Practice _____

FAMILY INFORMATION

Home Address _____
City _____ State _____ Zip Code _____

Mother's Name _____ phone _____
Email address _____
Place of Employment _____

Father's Name _____ phone _____
Email address _____
Place of Employment _____

Parents Marital Status _____

Child's Legal Guardian _____

Other than parents, who lives in the household? Include name and Age

1. _____
2. _____
3. _____
4. _____
5. _____

Names of Individuals that Child can be released to

Name _____ Relationship to Child _____

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 specialists? _____

How would you describe your child?

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 _____

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 _____

CURRENT DEVELOPMENTAL INFORMATION

Please circle your child's current level of functioning

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 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 _____

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, etc.
- 11. Hand preference Right _____ Left _____ Both _____ Not sure _____

If your child has difficulty with coloring, fastening or handwriting, please explain _____

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

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

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

Other _____

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 ____

Other _____

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-the-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?) _____

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? _____

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 any major concerns you have about your child.

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