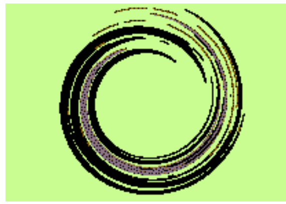

Crisalida

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2B – REGISTRATION FORM – CHILD AND FAMILY

CHILD'S DETAILS

CHILD'S NAME:______________________ TODAY'S DATE:________________
DATE OF BIRTH:_____________________ GENDER: ☐ Male ☐ Female
ADDRESS:____
___________________________________ FORM FILLED OUT BY:___________
PHONE: (Home)________(Mobile)____________(Work)____________________
E-MAIL:__________________Primary language spoken at home:___________
REFERRED BY:____

FAMILY INFORMATION

Mother's/Caregivers Name:__________________Occupation:__________
____
Father's/Caregivers Name:__________________ Occupation:_______________
____
Brothers & Sisters (Names & Birth dates):______________________________
____

Significant & Relevant Family Factors: (for example moves in residence, migration, significant family events, family history of disability, family relationships, illness)____
____
____
____

PHYSICIANS/SPECIALISTS (Including Therapists -Occupational, Physical, Speech; Neurologists, Psychologist, GP). Has your child previously attended any other facilities or seen other professionals (if possible, state name of agency/professional, why child saw professional, time period, and phone number)

NAME/SPECIALTY ADDRESS DATE PH. NUMBER
____
____
____
____
____
____

HEALTH COVER
Do you have Health/Extras Cover?______Name of cover:____________________

MEDICAL HISTORY
Pregnancy and birth details (any significant information):____________________
____
____
Current Medications. Give list and state reason:___________________________
____
Significant Illnesses/Dates (Describe):____________________________________
____
Hospitalizations/Dates (Describe):____
____
Accidents/Dates (Describe):____
____

Does your child have a vision problem? ☐ No ☐ Yes ____________________
Does your child have a hearing problem? ☐ No ☐ Yes _____________________

DEVELOPMENTAL MILESTONES
Please estimate ages: Crawl___________________ Sit alone__________________
Stand alone___________ Walk alone____________ Feed self_________________
Knife spreading__________ Knife cutting__________ Toilet trained___________
Dress self___________ Button/zips _____________ Single words ______________
Sentences___________
Mostly uses: ☐ Right hand ☐ Left hand
Mother's handedness: ☐ Right hand ☐ Left hand
Father's handedness: ☐ Right hand ☐ Left hand

EDUCATIONAL DETAILS

School Attended	Grade Level	Teacher/s

General Academic Performance (Describe strengths & weaknesses in school subjects): ____
____
____
____

Does your child have a classroom aide or any other additional special education or support services within the school system?__________________
____
____
____

MAIN CONCERNS:

☐ Learning difficulties (diagnosed or undiagnosed, needs specific teaching styles, etc)
____
____
____

☐ Gross motor (eg. falls a lot, walks with toes out, poor balance, clumsy, overactive or fears movement, poor eye-hand co-ordination, etc)______
____
____

☐ Fine Motor (struggles with/or has difficulty with writing, cutting, drawing, tasks involving two hands, hand preference, etc)
____

☐ Visual perceptual (letter reversals, reading problems, trouble with puzzles, etc) ____
____
____

☐ Cognitive Functioning (eg. Educational test results, other) ______________
____

☐ Self-regulation (eg. difficulty modulating own behaviour, tone of voice, speed, mood) ____
____

☐ Play (eg. difficulty turn taking, co-operating, lack of interest in age approp. toys) ____
____

☐ Behaviour (eg. difficulty interacting with other people; oppositional, withdrawn, angry, cries a lot; difficulty transitioning between activities or adapting to changes in routine) ___________________________________
____

☐ Speech/Language (expressive, receptive, oral sensitivity, fussy eater, seeks oral) ____
____

☐ Dressing/Toileting/Eating (eg. difficulty with shoelaces/fasteners, difficulty with fork/knife, puts clothes on backwards, etc):

☐ Friendships

☐ Other

Describe your child:

Describe your child's strengths/weaknesses/interests:

What are your major concerns?

What are your goals for your child?

Please prioritise order of therapy (if relevant). Number each box 1 – 4, 1 being the highest importance.

☐ Occupational Therapy
☐ Psychology
☐ Speech Therapy
☐ Family Therapy

Any special requests/outstanding questions?

Thank you for your time in completing this form.
All information is confidential.