Pediatric Therapy Studio

The following questionnaire is to be completed by the individualôs parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Pediatric Therapy Studio, LLC will hold information provided by you as strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law.

CLIENT DEMOGRAPHICS:

Name of Child: _____ _____ _____ (Last) (First) (MI)	
SS#: _____ /____ /_____	Gender: O Male O Female
DOB: ____/_____/____	Age: _____/_____
Current Diagnosis: ☐ Asperger's Syndrome (299.80) ☐ Autism (299.00) ☐ PDD-NOS (299.00) ☐ Other:_____	Date of Diagnosis:
Diagnosed by:	Age at Diagnosis:
Current Address:	Permanent Address: (if any)

PARENTS AND/OR GUARDIANS:

Motherôs Name:	Fatherôs Name:
SS#: _____ /____ /_____	SS#: _____ /____ /_____
DOB: ____/_____/____	DOB: ____/_____/____
Occupation:	Occupation:
Employer: Rank:	Employer: Rank:
Home Phone Number:	Home Phone Number:
Mobile Phone Number:	Mobile Phone Number:
Work Phone Number:	Work Phone Number:
Best Number to Reach: Home/Mobile/Work	Best Number to Reach: Home/Mobile/Work
Email Address:	Email Address:
Does either parentôs job require him/her to be away from home long hours or extended periods?	

Are parents _____married _____divorced _____ separated? If divorced, who has custody of minor? _____ If divorced, please provide a copy of the custody agreement.

If divorced, how long have the biological parents been divorced? _____

Please list the name(s) of the stepparents: _____

Is there a birth parent living outside the home: (circle one) MOTHER FATHER
Name: _____ Where do they live? _____

If birth parent(s) do not live in the childôs home, how much contact does the child have with the parent not having custody, with stepsiblings, etc.?

_____

_____

SIBLINGS

Name:	Age:	DOB:	Grade:
Name:	Age:	DOB:	Grade:
Name:	Age:	DOB:	Grade:
Name:	Age:	DOB:	Grade:
Name:	Age:	DOB:	Grade:

Please indicate any special needs or concerns regarding the other children living in your home:

_____

_____

_____

_____

Please indicate any concerns you have regarding the child for whom you are seeking services and these siblingsôrelationship(s):

_____

_____

_____

_____

Others: List any other people who currently live in your home?

Name	Age	Relationship to Child	Years Living in Home
1. _____	_____	_____	From_____ To_____
2. _____	_____	_____	From_____ To_____
3. _____	_____	_____	From_____ To_____
4. _____	_____	_____	From_____ To_____
5. _____	_____	_____	From_____ To_____

Are there any other people who have a significant role on how this child is raised?

_____

FAMILY PSYCHOLOGICAL HISTORY:

Is there a history in your immediate or in the mother's or father's extended family, of the following, and if so who?

Yes	No		Who
___	___	Autism Spectrum Disorders	_____
___	___	Learning Problem/Disabilities	_____
___	___	ADHD ï ADD ï Attention Problems	_____
___	___	Depression OR Bipolar Disorder	_____
___	___	Behavior Problems in School	_____
___	___	Anxiety Disorders (OCD, Phobias, etc.)	_____
___	___	Mental Retardation	_____
___	___	Psychosis/Schizophrenia	_____
___	___	Substance Abuse/Dependence	_____
___	___	Other Mental Health Concerns	_____

SCHOOL/CHILDCARE CENTER:

Name of School Center:	
Principal/Contact Person:	
Teacher's Name:	
Phone Number:	Address:
Email:	

PRIMARY INSURANCE:

Subscriberôs Name:	DOB of Subscriber:
Subscriberôs Employer:	
Carrier:	Case Manager:
Group #:	ID #:
Phone #:	Fax #:
Claims Address:	

SECONDARY INSURANCE:

Subscriberôs Name:	DOB of Subscriber:
Subscriberôs Employer:	
Carrier:	Case Manager:
Group #:	ID #:
Phone #:	Fax #:
Claims Address:	

MEDICAID:

ID#:	Type:
Name of Service Coordinator:	
County:	Region:
State:	Phone #:

OTHER PAYMENT SOURCE:

MEDICAL INFORMATION

PREGNANCY, DELIVERY AND FIRST YEAR:

Were there any complications with your pregnancy or delivery? If so, please explain.	
Did your child experience any illnesses during his or her first year? If so, please list the illnesses and how each was treated.	

PSYCHOLOCICAL HISTORY:

Has the individual had a psychological evaluation? Yes / No
If yes, please list the following information on the previous evaluation(s).

	Who	When	Copy Available
1.	_____	_____	Y / N
2.	_____	_____	Y / N
3.	_____	_____	Y / N
4.	_____	_____	Y / N

If yes, what were their general findings, recommendations and treatment? _____

_____

_____

_____

Please provide us with any other information from the other providers that you feel would be helpful to us in understanding your child: _____

_____

_____

_____

DEVELOPMENTAL HISTORY:

1. Please indicate the age at which your child did the following:

Rolled Over consistently _____
Sat up unsupported _____
Stood _____
Crawled _____
Walked Unassisted _____
Said 1st Word Intelligible to strangers _____
Said two-three word phrases _____
Used Sentences regularly _____
Toilet trained during the day _____
Dry through the night (6+ months) _____
Dressed Self _____

2. Please indicate if your child is experiencing any of the following:

Problems with eating _____
Isolated socially from peers _____
Problems making friends _____
Problems keeping friends _____
Problems getting to sleep _____
Problems controlling temper _____
Problems sleeping through the night _____
Trouble waking up _____
Fatigue/tiredness during the day _____
Nightmares _____
Bed wetting _____
Soiling _____
Problems with authority _____
Anxiety _____
Unmotivated _____
Stress from conflict between parents _____
Legal situation (anyone in the family) _____
History of abuse _____
Alcohol/drug use/abuse _____
School concentration difficulties _____
Grades dropping or consistently low _____
Sadness or Depression _____

3. List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had.

_____

_____

_____

_____

_____

4. Child's current height: _____Ft. _____Inches Weight: _____Lbs.

5. With which hand does the child write? _____

6. Does the individual have any vision problems? _____

Please list date of last vision test and who performed (pediatrician, optometrist & school)

_____

_____

_____

7. Does the child have any hearing problems?_____

Please list date of last hearing test and who performed (pediatrician, audiologist & school)

_____

_____

_____

8. Name of child's primary physician(s):

_____

Practice Name:

_____

Address:

_____

_____

Phone Number: _____ Fax Number: _____

(Please list information on additional Physicians on the back of the page)

EDUCATIONAL HISTORY:

1. List in chronological order all schools your child has attended:

Name	System	Year(s)	Grade	Special Ed?
Å				
Å				
Å				
Å				
Å				

2. Name(s) of current teacher(s)_____

3. Does your child's teacher have concerns about him/her (list):

_____

_____

4. What is your child's favorite subject/class? _____

5. What is your child's least preferred subject/class? _____

6. Has your child ever repeated a grade? Y/N If yes, what grade(s)? _____

7. If your child has been in Special Education, did they have a:

☐ 504 Plan ☐ I.E.P.
☐ Psychological Evaluation ☐ Speech Evaluation
☐ Behavior Intervention Plan ☐ Occupational Therapy Evaluation
☐ Physical Therapy Evaluation ☐ Adaptive Technology Evaluation
☐ Other(s):

_____

_____

_____

8. If your child has been in Special Education, how were they served?

☐ Consultation ☐ Resource Classroom
☐ Collaborative Education ☐ Team Taught Classes
☐ Pull-Out ☐ Self-Contained Classroom
☐ Special Program ☐ Psychoeducational Center

9. Child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.:

_____Football _____Karate _____Dance (type)_____
_____Baseball _____Piano _____Music (type)_____
_____Cheerleading _____Scouts _____ Gymnastics (type) _____
_____Basketball _____Soccer _____ other(s): _____
_____

10. List any special abilities, skills and strengths your child has:_____

_____

_____

DISCIPLINE INFORMATION:

Below is a wide range of discipline strategies that are frequently used. Please rate how likely you are to use each of the strategies listed:

Intervention	Very Unlikely				Very Likely	Effectiveness
Let situation go	1	2	3	4	5	___
Take away a privilege (ex., no TV)	1	2	3	4	5	___
Assign an additional chore	1	2	3	4	5	___
Take away something material	1	2	3	4	5	___
Send to room	1	2	3	4	5	___
Physical punishment	1	2	3	4	5	___
Reason with child	1	2	3	4	5	___
Ground child	1	2	3	4	5	___
Yell at child	1	2	3	4	5	___
Send to time out	1	2	3	4	5	___
List anything else you may do:						
_____	1	2	3	4	5	___
_____	1	2	3	4	5	___
_____	1	2	3	4	5	___

Go back and rate the THREE MOST effective strategies. That is, place a 1 by the most effective, a 2 by the next most effective, and a 3 by the third most effective. Please circle the LEAST effective. Please rate what percentage of discipline is handled by each of the following:
Father: _____% Mother:_____% Other:_____% (Please specify):_____

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

GENERAL INFORMATION:

Please list the five things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sisters, etc.

	Like Child to do More Often	Like Child to do Less Often
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

MEDICATIONS:

Please list any medications that your child is currently taking:		
Medication Name	Dosage	Length of Time Taken
Please list any supplements, vitamins, etc. that your child is currently taking:		
Medication Name	Dosage	Length of Time Taken

PYSCHOLOGICAL/MEDICAL TESTING:

Please list any psychological/medical testing that your child has completed:		
Test Name	Month/Year	Results

CURRENT MEDICAL CONDITIONS

Please list any medical diagnosis:	☐Cerebral Palsy ☐Autism/PDD ☐ ADHD ☐MR ☐Hyperactivity ☐ ADHD (Short attention span) ☐Physical/Speech delay ☐Vision/Hearing impairments ☐ODD (Noncompliance) ☐ Other:
Please list any current allergies that your child may have:	
Please list any special nutritional needs:	
Are immunizations up to date? Attach a copy of the childôs immunization records:	

CURRENT TREATING PHYSICIANS

Doctorôs Name:	Doctorôs Name:
Specialty:	Specialty:
Address:	Address:
Phone Number:	Phone Number:

Pertinent Information

Please state your childôs behaviors of concern:

_____

_____

_____

Please state the expectation/goals that you have for child while engaging in a behavioral program:

_____

_____

_____

Please list any other information that may be helpful while assessing and/or conducting therapy with your child:

_____

_____

_____

Please describe the problems your child is now having and what type of services you are seeking from us to address these problems. Please use back of this sheet for addition space.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SKILLS ASSESSMENT

LANGUAGE:

Does your childé ..		Comments
Match objects or pictures?	O yes O no	
Imitate actions of others?	O yes O no	
Follow directions without visual cues?	O yes O no	
Indicate his/her needs or wants?	O yes O no	Circle one: words pictures gestures
Imitate sounds or words when modeled?	O yes O no	
Use words to ask for things?	O yes O no	
Label items he or she sees or hears?	O yes O no	
Answer questions?	O yes O no	
Speak in sentences? (if no, skip remaining questions)	O yes O no	If yes, average length? 3 5 8+ words
Participate in conversations?	O yes O no	
What are your principal concerns regarding your childôs language?		

PLAY SKILLS

Does your childé ..		Comments
Look at books?	O yes O no	
Play with cause/effect toys (i.e.: Jack in the Box)?	O yes O no	
Complete task completion toys (i.e.: puzzles, beads)?	O yes O no	
Play with toys by using them like real items (i.e. uses a play spoon to pretend to eat)?	O yes O no	
Play simple games like ring around the rosy?	O yes O no	
Construct items using blocks, legos, or other items?	O yes O no	
Play games with rules (i.e.; memory)?	O yes O no	
Engage in dress up or role play (i.e.; pretending to be a barber?)	O yes O no	
Play appropriately on his or her own for up to 5 minutes?	O yes O no	
What are your principal concerns regarding your childôs play skills?		

SOCIAL SKILLS

Does your childé ..		Comments
Respond to his or her name by looking at you?	O yes O no	
Make eye contact when speaking to you?	O yes O no	
Greet you when you arrive home?	O yes O no	
Respond to others emotions?	O yes O no	
Attempt to involve you in something that he/she is doing to share interest (not b/c he or she needs your help)?	O yes O no	
Observe other children playing?	O yes O no	
Join in with other children when they are playing?	O yes O no	
Take turns in games?	O yes O no	
Verbally interact with peers?	O yes O no	
What are your principal concerns regarding your childôs social skills?		

SELF HELP SKILLS

Does your childé ..		Comments
Sleep through the night?	O yes O no	
Sleep in his/her own bed without supervision?	O yes O no	
Drink from a cup?	O yes O no	
Eat a variety of foods (i.e. fruits, veggies, meats, grains)?	O yes O no	
Use a spoon and a fork to feed himself or herself?	O yes O no	
Remove pull-down garments independently?	O yes O no	
Remove socks and shoes independently?	O yes O no	
Remove shirts independently?	O yes O no	
Put on pull-up garments independently?	O yes O no	
Put on socks and shoes Independently?	O yes O no	
Put on shirts Independently?	O yes O no	
Use the toilet independently?	O yes O no	
What are your principal concerns regarding your childôs self help skills?		

FINE MOTOR

Does your childé ..		Comments
Unwrap presents?	O yes O no	
Pour water or sand from one object to another?	O yes O no	
Turn doorknobs to open doors?	O yes O no	
Use one hand consistently?	O yes O no	
Use a crayon with hand NOT fisted?	O yes O no	
Copy lines and simple shapes?	O yes O no	
Write his or her own name?	O yes O no	
Use scissors?	O yes O no	
What are your principal concerns regarding your childôs fine motor skills?		

GROSS MOTOR

Does your childé ..		Comments
Walk up and down stairs with alternating feet?	O yes O no	
Walk around or step over items that are on the floor?	O yes O no	
Jump off the ground with both feet?	O yes O no	
Kick a playground ball to you?	O yes O no	
Throw a playground ball to you?	O yes O no	
Catch a ball when thrown?	O yes O no	
Show interest in sports?	O yes O no	
What are your principal concerns regarding your childôs gross motor skills?		

ACADEMIC SKILLS

Does your childé ..		Comments
Identify shapes, colors, numbers and letters?	O yes O no	
Identify locations, occupations, and functions of objects (i.e.; the refrigerator keeps things cold)	O yes O no	
Use pronouns, plurals and prepositions appropriately?	O yes O no	
Identify cause/effect relationships?	O yes O no	
What are your principal concerns regarding your childôs academic skills?		

CHALLENGING BEHAVIORS

Please list any challenging behaviors that your child may exhibit and complete the table accordingly.

Types of Behavior	Please describe the behavior.	What typically happens immediately before, or triggers the behavior?	How many times per day or week does this behavior occur? If the behavior lasts for more than 10 seconds, list the average duration of the behavior as well.	What typically happens after the behavior, or, what do you do when this behavior occurs?
Tantrums				
Failing to Follow Instructions				
Aggression				
Running Away/Eloping				
Self Injurious Behaviors				
Eating Inedible Objects (Pica)				
Other:				

SELF STIMULITORY BEHAVIORS

Please list any self stimulatory/repetitive behaviors that your child may exhibit and complete the table accordingly.

Types of Behavior	Please describe the behavior.	What typically happens immediately before, or triggers the behavior?	How many times per day or week does this behavior occur? If the behavior lasts for more than 10 seconds, list the average duration of the behavior as well.	What typically happens after the behavior, or, what do you do when this behavior occurs?
Vocal (repeating vocalizations, words or phrases)				
Preoccupations with items, topics, etc.				
Repetitive motor mannerisms (hand flapping, spinning items, lining up objects, etc.)				
Routine behaviors (insisting on the same cup, same route in the car)				

WHAT ARE THINGS THE PERSON LIKES AND ARE REINFORCING FOR HIM OR HER?

1. Food Items: _____

   _____

2. Toys and Objects: _____

   _____

3. Activities at Home: _____

   _____

4. Activities / outings in the community: _____

   _____

5. Other: _____

   _____

TREATMENT HISTORY

Please list any treatments that your child has received in the past and complete the table accordingly.

Type of Treatment	Service Provider or Clinician And Contact Information	How many hours per week was this treatment provided?	Dates of Treatment	Did you feel that this treatment was beneficial? Please explain.
Special Education Classroom			Start Date: End Date:	
Speech Therapy			Start Date: End Date:	
Occupational Therapy			Start Date: End Date:	
Physical Therapy			Start Date: End Date:	
Other ABA Program			Start Date: End Date:	
Other:			Start Date: End Date:	
Other:			Start Date: End Date:	
Other:			Start Date: End Date:	
Other:			Start Date: End Date:	
Other:			Start Date: End Date:	
Other:			Start Date: End Date:	
Other:			Start Date: End Date:	
Other:			Start Date: End Date:	

CURRENT TREATMENT AND SCHEDULE

Please list any treatments that your child is currently receiving and complete the table accordingly.

Type of Treatment	Service Provider or Clinician And Contact Information	How many hours per week is this treatment provided?	Start Date of Treatment	Do you feel that this treatment is beneficial? Please explain.
Regular Education Classroom			Start Date:	
Special Education Placement			Start Date:	
Speech Therapy			Start Date:	
Occupational Therapy			Start Date:	
Physical Therapy			Start Date:	
Other ABA Program			Start Date:	
Other:			Start Date:	
Other:			Start Date:	

Please complete the schedule to indicate your child's availability.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Please provide copies of the following documentation as applicable:

- ☐ Immunization Record
- ☐ IEP
- ☐ 504 Plan
- ☐ Psychological Evaluation (School/Private)
- ☐ Speech Therapy Progress Notes and Recommendations (School/Private)
- ☐ Occupational Therapy Progress Notes and Recommendations (School/Private)
- ☐ Physical Therapy Progress Notes and Recommendations (School/Private)
- ☐ Adaptive Technology Evaluation
- ☐ ISP – Babies Can't Wait, NOW Waiver and COMP Waiver
- ☐ Previous ABA Assessments and Behavior Plans
- ☐ EFMP Enrollment (Military)
- ☐ ECHO Application (Military)
- ☐ Custody Agreement/Guardianship
- ☐ Insurance Card
- ☐ Driver's License
- ☐ Military ID