The Sensation Nation Therapy Services Registration Form

Date_____ Location of Service_____
Child Name _____ Sex_____
(First) (M.I.) (Last)
Date of Birth_____
(Mm/dd/yy)

Mailing Address_____
City_____ State_____ Zip_____

Mothers Name_____ Home Ph_____
Email_____ Cell Ph_____
Fax_____ Work Ph_____
Address (if different from above) _____

Fathers Name_____ Home Ph._____
Email_____ Cell Ph_____
Fax_____ Work Ph_____
Address (if different from above) _____

Preferred method of contact: _____

Emergency Contacts
Name two (other than parent)
1. Name_____ Home Ph_____
Relationship_____ Cell Ph_____

2. Name_____ Home Ph_____
Relationship_____ Cell Ph_____

Medical
Child's current primary physician_____ City_____
Phone_____Medications/Restrictions_____
_____

Medical Diagnosis_____
List any precautions (i.e., medications, activities, foods, etc.).
_____
_____

School Background Information
Current school attending: _____Phone:_____
City: _____ District_____
Teacher name: _____Grade:___Aide/shadow_____
What type of classroom setting? _____
Previous school(s) attended: _____

Therapy History

Occupational Therapy

At what age did your child start receiving OT? _____
Where is your child currently receiving OT? _____
How many times per week? _____
Please list where your child has had services in the past:
_____
_____
__
What goals/issues were addressed?
_____
_
_____

Physical Therapy

At what age did your child start receiving PT? _____
Where is your child currently receiving PT? _____
How many times per week? _____
Please list where your child has had services in the past:
_____
_____
__
What goals/issues were addressed?
_____
_
_____

Speech Therapy

At what age did your child start receiving speech therapy? _____
Where is your child currently receiving speech therapy?_____
_____
How many times per week? _____
Please list where your child has had services in the past:
_____
_____
__
What goals/issues were addressed?
_____
_
_____

Background information

Has your child had a recent vision test? Yes _____ No _____
Does he or she wear glasses? Yes _____ No _____

Has your child had a recent hearing test? Yes _____ No _____
Does your child have a history of seizures? Yes _____ No _____

1. When was the most recent seizure? _____
2. What type of seizure(s) has your child experienced? _____
3. What medication(s) have been prescribed? _____

_____

Please list all childhood illnesses:

_____
_____
__

List any surgeries and the age of your child when they occurred:

_____
_____
__

Complications, illnesses, or infections during pregnancy?
Yes _____ No _____ If yes please explain: _____
Complications during Labor and/or delivery?
Yes _____ No _____ If yes please explain: _____

Was your child born:
Prematurely yes _____ No _____ At full term? Yes _____ No _____
Birth weight? _____ Breast Fed? _____ If yes, for how long? _____
Were there problems with feeding? _____ Breathing? _____ Sleeping? _____
Please explain: _____
_____
_____
__

Developmental milestones

Please provide approximate ages at which each occurred, if applicable.
Roll over _____ Crawl _____ First word _____ Say sentences _____
Sit _____ Walk _____ Run _____ Jump _____ Throw _____
Ride bike _____ Skip _____
Has your child established a preferred hand for fine motor tasks? _____
Has your child established hand dominance? _____ If yes which one? _____

Behavioral

Does your child receive behavioral intervention (i.e. ABA)? _____
What company is currently providing these services? _____
How many hours per week is your child receiving behavioral therapy? _____
Does your child routinely demonstrate inappropriate behavior? Yes _____ No _____
If yes, what behavior(s)? _____
_____

THE SENSATION NATION THERAPY SERVICES
Activities of Daily Living Checklist

P = Skill Present A = Skill Absent E = Skill Emerging
Please check mark one answer for each row.

Feeding	P	A	E
Finger foods			
Uses spoon			
Uses fork			
Uses knife to butter bread and cut soft food			
Uses sawing motion with knife			
Drinks from bottle or spout cup			
Drinks from open cup			
Pours liquid from carton or pitcher into cup			
Twists open lid from juice or water bottle			
Pierces juice drink with straw			
Opens and closes zip-lock bags			
Opens pre-packaged individual snacks			

Comments: _____

Self Care	P	A	E
Opens mouth for teeth to be brushed			
Thoroughly brushes teeth independently			
Prepares toothbrush with toothpaste			
Brushes or combs hair independently			
Allows nose to be wiped			
Blows nose into held tissue			
Wipes nose with tissue			
Blows and wipes nose without being asked			
Rubs hands together under running water to clean			
Turns water on and off and retrieves soap			
Washes hands thoroughly			
Dries hands thoroughly			
Washes body thoroughly			
Dries body thoroughly			
Washes and dries face thoroughly			

Comments: _____

Dressing	P	A	E
Assist with pullover and front opening shirts(pushes arms through)			
Doffs t-shirt or sweater (without fasteners)			
Dons t-shirt or sweater			
Dons and doffs front opening shirts (not including fasteners)			
Dons and doffs front opening shirts (including fasteners)			
Zippers			
Snaps			
Buttons			
Dons/doffs pants with elastic waist			
Dons and doffs pants with fasteners			
Doffs socks and shoes			
Dons socks			
Puts shoes on correct feet			
Manages Velcro fasteners			
Ties shoe laces			

Comments: _____

Toileting	P	A	E
Assists with management of clothing			
Manages toilet seat, gets toilet paper, and flushes toilet			
Manages clothes before and after toileting			
Wipes self thoroughly after urinating			
Wipes self clean after bowel movement			

Comments: _____

Management of Bladder and Bowel	P	A	E
Consistently stays dry throughout the day			
Takes self to bathroom for bowel movements, no accidents			

Comments: _____