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| **REGISTRATION INFORMATION** |

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| **IMPORTANT: Formal Name of Child and Parents MUST MATCH Passport or National ID** |
| Child’s Name: |       | Date Form Completed: |       |
| Person Completing Form: |       | Relationship to Child: |       |
| Gender: |  Male  | Female  | Child’s Nationality:  |       |
| Age: |       | Race / Ethnicity: |       |
| Date of Birth (YY/MM/DD): |       | Child’s Passport / Identification No.: |       |
| Place of Birth: |       |  Current City: |       |
| Name Child Prefers to Be Called: |       | Date Moved There (YY/MM/DD): |       |
| Home Address: |       |
| Child’s Pediatrician/Primary Doctor |       |
| **Father’s Information** |
| Name:  |       | Primary Contact: |  Yes  |  No  |
| Email Address: |       | Company Name:  |       |
| Mobile Number:  |       | Occupation:  |       |
| **Mother’s Information** |
| Name:  |       | Primary Contact: |  Yes  |  No  |
| Email Address:  |       | Company Name:  |       |
| Mobile Number:  |       | Occupation:  |       |
| **Other / Guardian’s Information** |
| Name: |       | Primary Contact: |  Yes  |  No  |
| Email Address:  |       | Company Name: |       |
| Mobile Number:  |       | Occupation: |       |
| Relationship to Child: |       | Legal Guardian:  |  Yes  |  No  |
| **Language and School Information** |
| What language did your child learn when he/she first began to talk?  |       |
| What language does your child most frequently use with adults at home? |       |
| What language is used mostly frequently between adults in your home? |       |  |
| What language do you use most frequently to speak to your child? |       |
| What language(s) are spoken at school? |       |
| Name of school: | Grade / year level: |
|        |  |       |
| **General Family Information** |
| Siblings – Please indicate names and ages      |

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| **PATIENT INFORMATION** |
| **PATIENT INFORMATION** |

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| **Strengths and Interests** |
| What are your child’s strengths?       |
| What qualities about your child do you particularly enjoy?      |
| What motivates your child?      |
| What are your child’s hobbies / interests?       |
| **Social & Sensory** |
| Does your child over or under react to: Smell/Scent Touch Sound Light Movement |
| Please describe: |       |
| Is your child: |  Shy |  Social | Other |
| If other, please describe: |       |
| Does your child have friends?  |  Yes, mostly peers |  Yes, mostly adults |  No |
| **Referrer**  |
| Who has referred the child?  |  |
| May we contact the referrer for additional information or clarification? |  Yes |  No |
| If Yes, please provide Name: |       |  Contact: |       |
| Do you agree with this referral?  |  Yes |  No | If no, please explain: |
|       |
|  |
| Does your child’s school/teacher have any concerns about attention, behavior, motor skills, or academic performance? Please describe: |
|       |

 |
| **REFERRAL INFORMATION** |
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| **General Areas of Concern** |

Do you have any concerns about how your child... |

|  |  |  |  |
| --- | --- | --- | --- |
| Talks? | Yes | No | A Little |
| Makes speech sounds? | Yes | No | A Little |
| Understands what you say? | Yes | No | A Little |
| Uses their hands and fingers to do things? | Yes | No | A Little |
| Uses their arms or legs? | Yes | No | A Little |
| Behaves? | Yes | No | A Little |
| Gets along with others? | Yes | No | A Little |
| Is learning to do things for themselves? | Yes | No | A Little |
| Is learning preschool or school skills? | Yes | No | A Little |
| Comments: |       |

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| **DEVELOPMENTAL HISTORY** |

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| **Specific Diagnoses** |
| Does your child have any specific diagnoses?  |
|       |
| Please describe the symptoms about which you are most concerned currently: |
|       |
|  |
| Does your child use any adaptive equipment? |  Yes |  No |
| Is yes, please list: |       |

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| **Birth History** |
|  Premature |  Birth Complication |  Complications after birth |  Uncomplicated |
| How was your child’s health after birth?  |  Excellent |  Good |  Fair |
| Comments: |       |
| Was your child adopted? |  Yes No | If yes, at what age?  |       |
| **Medication / Allergies** |
| Does your child take any medication / vitamins? Yes No |
| If yes, please list with dosage and frequency: |       |
|  |
| Does your child have any allergies or sensitivities?  |
|  Yes (Medication) |  Yes (Food) |  Yes (Other) |
| If yes to any, please give details: |       |
| **Developmental Milestones** |
| Responding to mother (0-1 month) |  Delayed  |  On Time |  Unknown |
| Sitting alone (6-11 months) |  Delayed |  On Time |  Unknown |
| Using index finger to point (8-12 months) |  Delayed |  On Time |  Unknown |
| Walking alone (11-15 months) |  Delayed |  On Time |  Unknown |
| Speaking first word (9-13 months) |  Delayed |  On Time |  Unknown |
| Putting words together (15-28 months) |  Delayed |  On Time |  Unknown |
| **Hearing & Vision** |
| Date of Latest Hearing Test: |       | Date of Latest Vision Test: |       |
|  Normal |  Abnormal |  Unknown |  Normal |  Abnormal |  Unknown |
| If abnormal, please describe: |       | If abnormal, please describe:  |       |
|  |  |
| **List any previous evaluations, treatment, or consultation. Provide dates if possible. Please attach reports and/or test results if available.** |
| Comments:  |       |
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| **TREATMENT AND COMMUNICATION PREFERENCES** |

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| --- |
| **Treatment Preferences** |
|  Are you seeking a specific type of service(s)? Please check all that apply: |
|  Developmental-Behavioral Pediatrician |  Physical Therapy |
|  Speech-Language Therapy |  Psychology/Psycho-educational Assessment |
|  Feeding/Swallowing |  Psychology Therapy/Counseling |
|  Occupational Therapy |  Learning Support/Special Education |
|  Behavioral Therapy/ABA |  Audiology |
|  Diagnosis/Diagnostic Evaluation |  I’m not sure, I need more information |
|  Are you seeking evaluation / treatment with a specific clinician or specialist? Yes No |
|  Is yes, please give details: |       |
| **Communication Preferences** |
|  I authorize LIH Olivia’s Place to communicate medical information to me via email: Yes No |
|  Would you like to be added to our mailing list?  | Yes No |
|  If yes to either, please provide email address: |       |
|  I give consent to receive information and appointment reminders via SMS: Yes No |
|  If yes, please provide mobile phone number: |       |
|  How did you hear about LIH Olivia’s Place? |       |

 |
| *Thank you for completing this form, we will contact you to schedule an appointment or to discuss your child’s needs further. We respect your privacy and all information will be kept confidential.* |