568 Communipaw Avenue
Jersey City, NJ 07304
T: 2013090198
LM4SDJC@gmail.com
www.LM4SD.com

Registration and Referral Information

Family Information

Child's name_____ Birth Date_____ Age _____
Home/Cell Phone Number _____/_____
Parent/Caregiver(s) name(s):
_____
Siblings? yes no How many?_____Name(s): _____
Physical &/ Dietary Restrictions:_____
_____
Has your child ever had a seizure? ❑ Yes ❑ No If Yes, please explain:_____
Address:
_____
Email:
_____

EMERGENCY CONTACT INFORMATION

In case of emergency, contact:
Person #1 authorized to pick up child (Full Name & Relationship):
Relationship:_____
Cell Phone: _____ Home Phone:_____

Person #2 authorized to pick up child (Full Name & Relationship):
Relationship:_____
Cell Phone: _____ Home Phone:_____

Physician Name:_____
Phone:_____

***A doctor's referral is mandatory in order to receive therapy services.**

Person #2 authorized to pick up child (Full Name Relationship):

_____

LITTLE MILESTONES for SMALL DISCOVERIES

Physician Name:_____
Phone:_____
Who referred this child for an evaluation?
_____

Reason for referral?
_____

What are your child's strengths?
_____

_____

_____

What are your primary concerns/goals for therapy regarding your child?
_____

_____

_____

_____

School Information

Grade: _____ Hand preference: Right Left Both
Does your child receive special instruction or have an established IEP or 504 plan?
no yes
Does your child receive school-based therapy?(circle all that apply)
OT PT Speech and Language Adaptive PE

Medical History and Family Background

Any difficulties during pregnancy or delivery? No Yes If yes please describe:
_____
_____
_____
Length of pregnancy: _____ Birth was: Vaginal Caesarian Breech
Chronic ear infections? no yes Tubes placed _____ sets of tubes

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Current prescribed medications:

_____

Known allergies:

_____

Special Diet (GFCF, Ketogenic, pureed food only, tube feeding, etc.):

_____

Medical precautions:

_____

Diagnosis given by other health care professionals?

_____

Hospitalizations, date(s) and length of stay:

_____

_____

Surgeries?

_____

Currently receiving services from other health care professionals (circle all that apply):
Psychologist PT Speech and Language Nutritionist Behavioral Specialist
Other: _____
Any family members with diagnosed or undiagnosed learning disabilities, mental health or medical diagnoses? Yes No

Developmental History

Please indicate the approximate age your child achieved the following developmental milestones:
rolling _____sitting alone_____ crawling on all 4s_____ pull to stand _____
walking_____first word _____ combined words_____finger feeding _____
eating with a spoon_____cutting with scissors_____
hopping on one foot _____riding a bike _____

Please check each of the areas which interfere with your child's ability to independently engage in his/her activities of daily living:

<u>Self-Care</u>

- ❑ Difficulty feeding self
- ❑ Difficulty managing fasteners or clothing (e.g. buttons, zippers)
- ❑ Other _____

<u>Behavioral/Organizational Skills</u>

- ❑ Poor attention/ distractible
- ❑ Difficulty following directions
- ❑ Difficulty following established routines
- ❑ Disorganized (e.g. room, backpack)
- ❑ Difficulty with transitions (e.g. in and out of home, into/out of car)
- ❑ Sensitive to other people in immediate vicinity
- ❑ Other _____

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Pre-Writing/ Handwriting/ Visual Motor Skills

- ❑ Alternates hands when coloring or writing
- ❑ Difficulty imitating circle, square, or triangle
- ❑ Difficulty with writing legibility
- ❑ Difficulty copying from the board
- ❑ Other _____

Visual Perceptual Skills

- ❑ Difficulty with colors
- ❑ Difficulty remembering numbers or letters
- ❑ Letter reversals when writing
- ❑ Confuses left and right
- ❑ Other _____

Sensory Processing Skills (please circle sensory responses)

- ❑ Proprioception (i.e. body awareness) seeking/avoiding
- ❑ Vestibular (balance) seeking/avoiding
- ❑ Touch seeking/avoiding
- ❑ Auditory (hearing) seeking/avoiding
- ❑ Oral motor (mouth) seeking/avoiding

Please describe your primary concerns:

_____
_____
_____
_____
_____
_____

Social and Occupational History

For the following, indicate Often Sometimes or Rarely

Does your child:
Socialize with family and close friends? _____
Communicate needs and wants effectively? _____
Hard to make friends? _____
Tend to interact/play with younger children? _____
Enjoy time alone? _____
Tolerate change in routine? _____
In the community, does your child:
Tolerate running errands? _____
Enjoy eating in restaurants? _____
Attending birthday parties? _____
Attending family gatherings? _____

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Emotional Response, Play, And Self-Regulation

Check all that apply.

Emotional:

__ difficulty accepting changes in routine (to the point of tantrums)
__ gets easily frustrated
__ often impulsive
__ functions best in small group or individually
__ variable and quickly changing moods; prone to outbursts and tantrums
__ prefers to play on the outside, away from groups, or just be an observer
__ avoids eye contact
__ difficulty appropriately making needs known

Play:

__ difficulty with imitative play (over 10 months)
__ wanders aimlessly without purposeful play or exploration (over 15 months)
__ needs adult guidance to play, difficulty playing independently (over 18 months)
__ participates in repetitive play for hours; i.e., lining up toys cars, blocks, watching one movie over and over etc.

Self-Regulation:

__ excessive irritability, fussiness or colic as an infant
__ can't calm or soothe self through pacifier, comfort object, or caregiver
__ can't go from sleeping to awake without distress
__ requires excessive help from caregiver to fall asleep; i.e., rubbing back or head, rocking, long walks, or car rides

Internal Regulation (The Interoceptive Sense):

__ severe/several mood swings throughout the day (angry to happy in short periods of time, perhaps without visible cause)
__ unpredictable state of arousal or inability to control arousal level (hyper to lethargic, quickly, vacillating between the two; over stimulated to under stimulated, within hours or days, depending on activity and setting, etc.)
__ frequent constipation or diarrhea, or mixed during the same day or over a few days
__ difficulty with potty training; does not seem to know when he/she has to go (i.e., cannot feel the necessary sensation that bowel or bladder are full
__ unable to regulate hunger; eats all the time, won't eat at all, unable to feel full/hungry

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Please provide any additional information that will help to better understand your child:

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