Date:_____

Primary area(s) of concern: Sensory Play Feeding Social Emotional
Self-care Gross Fine Handwriting

Child's Name:_____ Age:_____ DOB:_____ male/female

Address:_____ City:_____ Zip:_____

Adopted: At what age:_____ From where:_____ siblings/ages:_____

School:_____ Grade:_____ Classroom type:_____ Educational DX:_____

Parent Name:_____ Cell:_____

Email:_____ Home:_____

Parent Name:_____ Cell:_____

Primary Insurance:_____ Subscriber:_____ DOB:_____

ID Number:_____ Group Number:_____

Seconday Insurance:_____ Subscriber:_____ DOB:_____

ID Number:_____ Group Number:_____

Physician Name:_____ Clinic:_____

Address:_____ Phone:_____ Fax:_____

Medical DX:_____

Medical History (surgery, hospitalization, chronic illness, allergies):_____

Please describe what your current concerns for your child are at this time: (ie related to academics, ADLs, relationships, sensory, speech, motor, play, feeding…)

How can we be most helpful to you and your child?	How long can your child sit at a table and pay attention:
	Relationships/play with others:
Self-Care (dressing, eating, bathing):	Interests (appropriate play):
Coordination (gross and fine):	Following directions (1 step, 2 step, more):
Flexibility with change (transitions):	Precatutions:

Please email this completed form to sensorysystemsclinic@gmail.com

We will contact you to schedule an appointment and answer any questions within 2 business days.