Admissions Packet

Welcome to WE Play/Sensawee Play.

We would like to start off by thanking you for taking the time to fill out our admission papers. Below you will find a series of general questions about your child as well as his/her developmental history and current functioning abilities. We appreciate any information you have for us. If you would like to supplement this questionnaire with any additional information about your child please bring those papers along with the admissions papers to your first session.

Please feel free, as always, to contact us by phone or email with any questions you may have.

Sincerely,
The Staff at WE Play/Sensawee Play (Florie, Jen, Katelyn, Kathy, Megan, Abbi & Ruhi)

Client General Information

Name: _____ Sex: __M / F__

Date of Birth: _____

Phone Number: _____

Address (#1): _____

Address (#2): _____

City: _____ State: _____ Zip Code: _____

School: _____

Grade in School: _____

Teacher/s Name: _____

Referring Physician: _____

Diagnosis: _____
We require a prescription from your pediatrician to leave on file should insurance requests it. We are happy to suggest diagnosis but legally we are not allowed to officially diagnose. Your prescription should have the following on it: Child's Full Name, Date of Birth, Diagnosis Code, Frequency (Ex. 1-2 times a week) and Duration (6-12 months).

How did you hear about us? _____

Emergency Contact (name & number): _____
(Person you give permission to leave a message with in case of an accident or a therapist emergency)

Monthly Statement Information

Payment is due at time of service.
ALL monthly statements and most correspondence will be done via email.
Monthly Statements will be emailed at the beginning of every month for the month prior.

Please email our monthly statements to:

Contact Name: _____

Email Address: _____

If you would like statements to go to a second contact please fill out below:

Contact Name: _____

Email Address: _____

Service Providers

Service	Provider	Frequency
_____	_____	_____
_____	_____	_____

Parent / Legal Guardian Information

	Parent	**Parent**
Name:	_____	_____
Address:	_____	_____
(if different than child's)	_____	_____
Phone Number:	_____	_____
Cell Number:	_____	_____
Work Number:	_____	_____
Email:	_____	_____
Age at birth of Child:	_____	_____
Overall Health:	_____	_____
Marital Status:	_____	_____
Education:	_____	_____
Occupation:	_____	_____

Other individuals living in the home consistently:

Name	Age	Relationship to the Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child received Occupational therapy services in the past? _____

If yes, at what age did your child begin therapy? _____ How long did/has your child receive(d) therapy? _____ How frequently was/is your child seen for therapy? _____ Who was your child's Occupational Therapist? _____

Has/Does your child receive other interventions? No _____ Yes _____
If yes, please indicate below:

INTERVENTIONS	HOW LONG
Speech therapy	
Physical Therapy	
Applied Behavior Analysis (ABA)	
DIR (Floortime)	
Others _____	

Pregnancy History

This child is:

- ☐ A natural child
- ☐ An adopted child with no previous medical history available
- ☐ An adopted child with medical history available

This child was the product of the ____ pregnancy.
The mother miscarried _____ times prior to this pregnancy.
Out of the _____ pregnancies carried to term prior to this one, there were _____ live births and _____ stillbirths.
This child has _____ siblings older than him/her.

Complications experienced by the mother while pregnant with this child included:

_____

_____

_____

_____

While the mother was pregnant, the parents:

	Parent	Parent
Smoked regularly	☐	☐
Smoked occasionally	☐	☐
Had two or more drinks daily	☐	☐
Used illegal drugs regularly	☐	☐

Birth History

Length of Pregnancy: _____ Weight at Birth: _____ Length: _____

Please specify the conditions of your child's birth (check all that apply):

☐ Vaginal ☐ Forceps ☐ Vacuum ☐ C-Section

☐ Premature ☐ Post mature ☐ Full-term

Labor had to be induced because of:

_____

Complications during labor included:

_____

Any indications of difficulties at birth? Please explain:

_____

Child was in intensive care because of:

_____

Child was in intensive care for _____ days.

Length of stay in hospital: _____

Developmental History

When were your child's difficulties first noted? _____

Who was the first person to notice these difficulties?

_____

Please describe those difficulties?

_____

_____

_____

_____

Complications during development included:

☐ Seizures ☐ High fever ☐ Feeding difficulties ☐ Sleep disturbances
☐ Allergies ☐ Serious illness ☐ Chronic ear infection ☐ Genetic disorder
☐ Constipation ☐ Other: _____

If yes to any of the above, please describe:

_____

_____

_____

_____

Does your child wear glasses? _____

If yes, what visual correction is this for? _____

What Dr. did your child see? _____

Has your child had audiological testing? _____

If yes, what were the findings? _____

What Dr. did your child see? _____

Please provide your child's age, to the best of your memory, of when he/she accomplished the following:

Roll over: _____ Reach for objects: _____ Sit alone: _____

Belly crawling: _____ Crawling: _____ Cruising: _____

Walk alone: _____ First words: _____ Talking: _____

Finger feed: _____ Fed self with spoon: _____ Scribble: _____

Toilet train: _____ Hopping: _____ Jumping: _____

Skipping: _____ Running: _____ Riding a tricycle: _____

Riding a bicycle: _____ Jump Rope: _____

List of serious illness or hospitalizations and date:

Illness	Date	Length of Stay
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any medication/supplements your child has taken or is taking regularly:

Medication	Reason for it	Prescribed by
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child's Current Behavior

Does your child have difficulty with sleeping? _____
If yes, please describe:

_____

_____

_____

What is/are the hardest time(s) of day? _____
Please comment:

_____

_____

_____

Describe the impact of the aforementioned on the child and other family members.

_____

_____

_____

What types of activities do you/your spouse enjoy doing with your child?

_____

_____

_____

Describe a typical day with your child.

_____

_____

_____

Please describe your child's strengths:

_____

_____

_____

Please describe your child's difficulties:

_____

_____

_____

Please list areas where you would like to observe improvements with your child:

Within the next three months:

_____

_____

Within the next year:

_____

_____

Please list the behaviors you would like to see:

Increased

_____

_____

Decreased

_____

_____