Adoption and Attachment Therapy Partners LLC

Child Registration Form

PLEASE PRINT

Name of Child____ Birthdate_______________________

Parent's name

(Parent 1)____ DOB_____________________________

(Parent 2)____ DOB_____________________________

Address____

____

Contact Information

(Daytime)____ (Evening)_______________________

(Parent 1) Cell Phone__________________________________

(Parent 2) Cell Phone__________________________________

(Parent 1) Email______________________________________

(Parent 2) Email______________________________________

Level of Education

(Parent 1)____

(Parent 2)____

(School of Child) _____________________________________ Grade___________________________

Others living at home:

Name	Sex	Birth date	Age	School/Grade

Arleta James, PCC
Adoption & Attachment Therapy Partners LLC
3501 E Royalton Road
Broadview Heights, OH 44147

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Parent 1 Employed by____

Business Telephone____

Soc. Sec. #____

Parent 2 Employed by____

Business Telephone____

Soc. Sec. #____

Family Physician____

Referred by____

Telephone#____

Chief Complaint & Problem____

____

____

Is Child Adopted? _________________________

If So, At What Age? _______________________

Child's First Name Prior to Adoption____

Complications of Birth & Delivery____

____

____

Have there been any physical or emotional separations (i.e. death, hospitalizations, depression) between child and caretaking adult during the first 26 months of life? ____

If so, please elaborate in CHILD'S HISTORY report.

Is there, as far as you know, any possible history that could be considered abusive? If so, indicate type(s) and age of occurrence. ____

____

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If it is hard to remember ages, please simply check the problem areas or areas you feel were/are advanced or slow in development.

Age he/she:

held head up __________

crawled __________

walked with help __________

used sentences _________

fed self __________

dressed alone __________

turned over __________

sat __________

walked alone ___________

was weaned ___________

said "no, no" to everything ___________

smiled at parents ___________

pull up at crib ___________

said 4-10 words ___________

helped with dressing ___________

dry during day ___________

dry during night ___________

Does he/she:

have blank spells ___________

rock ___________

shuns attention __________

have temper tantrums ___________

have falling spells ___________

have unusual fears ___________

bump head ___________

hold breath ___________

show dare devil behavior ___________

have sleep problems ___________

have eating problems ___________

Is he/she:

shy or timid __________

affectionate __________

well coordinated __________

impulsive __________

stubborn __________

right/left handed __________

clumsy __________

PREVIOUS TESTING OR THERAPY:

Dates: ____

____

Place: ____

____

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With whom: ____

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