THERAPEUTIC APPROACH
TO GROWTH

Personal Information

Name of Child: ____________________________ Date of Birth: ___________________

Parent: ___________________________________ Email: _________________________

Parent: ___________________________________ Email: _________________________

Address: ____

Phone Number(s): Home: ____________ Cell: _______________ Work: _____________

Name and Age of Siblings: ____

Do siblings have a diagnosis? _______Yes _______No

If yes, please explain: ____

Language(s) spoken in the home: ____

Person(s) who contributed to filling out this form: _________________________________

Date: __________________

Diagnosis: ____

Diagnosed by: ____

Date of Diagnosis: _____________

Summary of previous and current treatments (for the current problems)

Medication

Please list all current medications (including homeopathic, herbal or vitamin-based remedies).

1. ____________________ ________________ ____________________
Medication for treatment for start date

2. ____________________ ________________ ____________________
Medication for treatment for start date

3. ____________________ ________________ ____________________
Medication for treatment for start date

Food Allergies and Diet

Allergies: ____

Special Diet: Yes _______ No__________ If so, what? ______________________________

____

Sleep patterns

Please summarize any concerns you have about your child's sleep:

Self care

Please list any concerns you have about your child's self care:

Behavior

Please describe any concern you have about your child's behavior:

Social Behaviors:

Please describe any concern you have with your child's interaction with others

Educational Background

Does your child attend school? ________ Yes _______ No

If yes, what school does your child attend? ___________________________ Grade: ______________

Please describe any concern about your child's school situation:

Main Concerns and Goals:

Reasons for requesting services from TAG, Inc. (describe main problems that are of concern to you or questions that you are seeking answers for along with short and long term goals):

The following questions may be difficult or may not appear directly relevant to your child. Do your best to answer and do not worry if you do not know an answer.

	Yes	No	Unsure
Emotional outbursts			
Uncomfortable when touched			
Self injurious behaviors			
Self stimulatory or sensory seeking behaviors			
Repetitive behaviors			
Uncomfortable with transitions and changes (activities, people, places, etc.)			
Seems easily overwhelmed			
Easily frustrated			
Becomes easily disorganized			
Distractible			
Displays aggression toward self			
Displays aggression toward others			
Stubborn, inflexible, uncooperative			
Highly sensitive; problem taking criticism			
Gives up easily			
Easily scared. (Indicate specific fears)			
Overly serious			
Lacks motivation			
Doesn't follow through with responsibilities			
Hypersensitive to sounds			
Often seems confused about past, present and future, or about timing of events			
Restless, constantly moving, can't sit still			
Impulsive, does not seem to think before acting			
Frequently rubs eyes during tasks requiring visual attention			
Difficulty completing homework			
Uncomfortable around crowds (stores, parties, restaurants, etc.)			

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	Yes	No	Unsure
Loses interest quickly			
Has difficulty following daily routines			
Picky eater			
Eating too slow or too fast			
Poor table manners			
Excessive spilling			
Does not appear interested in surroundings			
Does not seem to hear when talked to; often asks to repeat			
Slow and delayed responses when talked to and when asked to do something			
Seems passive; avoids strenuous physical activities			
Appears floppy; often leans against people or walls			
Fatigues easily; always seems tired			
Passive unless encouraged to engage in activity			
Poor handwriting			
Bumps into objects and/or people			
Clumsy or uncoordinated			
Poor speech articulation			
Lack of friends			
Difficulty getting along with people			
Tends to control others			
Difficulty falling asleep or staying asleep			
Slow to rise in the morning			

Responsible party signatures

1. ____
Print name

____ ____________________
Signature Date

2. ____
Print name

____ ____________________
Signature Date

When you have completed this questionnaire, please email or mail it back to us to:

TAG, Inc.
9466 Black Mountain Road, Suite 100
San Diego, CA 92126

Thank you