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: __________________

Health Insurance Provider: ____

Type of Plan: ____

Diagnosis: ____

Diagnosed by: ____

Date of Diagnosis: _____________ Age of Diagnosis: ______________________

Current Clinicians: (Please include contact information)

Pediatrician: ____

Allergist: ____

Neurologist: ____

Psychologist/Psychiatrist: ____

Speech Pathologist: ____

Occupational Therapist: ____

Behavioral Therapist: ____

Music Therapist: ____

Other: ____

Previous and Current Treatments: (Speech, Occupational Therapy, Behavioral Therapy, Other DIS Services).

Treatment 1:
Type of Treatment:

Treatment Provider:

Duration of Treatment:

Child's Age

Treatment 2:
Type of Treatment:

Treatment Provider:

Duration of Treatment:

Child's Age

Treatment 3:
Type of Treatment:

Treatment Provider:

Duration of Treatment:

Child's Age

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Treatment 4:
Type of Treatment:

Treatment Provider:

Duration of Treatment:

Child's Age

Has your child's hearing been tested? Yes _______ No_________

If yes, when?____

What were the results? ____

History of ear infections? ____

Has your child's vision been tested? Yes _______ No_________

If yes, when? ____

What were the results? ____

Medication

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

1. ____________________ ________________ ____________________
Medication for treatment for start date

____
Prescribed by

2. ____________________ ________________ ____________________
Medication for treatment for start date

____
Prescribed by

3. ____________________ ________________ ____________________
Medication for treatment for start date

____
Prescribed by

4. ____________________ ________________ ____________________
Medication for treatment for start date

____
Prescribed by

Food Allergies and Diet

Allergies: ____

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

____

Disorders of Sleep

What is his/her sleep pattern? ____

____

Does he/she sleep by him or herself? ____

____

Does he/she sleep all night? ____

____

Does he/she have night terrors/nightmares? ____

____

Self Help Skills

Please list your child's current level of functioning on the following skills:
Toileting:

____
____
____
____

Feeding:
____
____
____

Dressing:

____
____
____
____

Grooming:

____
____
____
____

Behavior

Please describe any problematic behaviors. Antecedents refer to causes or precipitating events, instructions or situations.

Non Compliance: _______Yes _______ No

Frequency (daily, weekly, monthly) and Duration:

____

Antecedents:

____

Consequences used:

____

Tantrums: _______Yes _______ No

Frequency (daily, weekly, monthly) and Duration:

____

Antecedents:

____

Consequences used:

____

Aggression: _______Yes _______ No

Frequency (daily, weekly, monthly) and Duration:

____

Antecedents:

____

Consequences used:

____

Running Away: _______Yes _______ No

Frequency (daily, weekly, monthly) and Duration:

____

Antecedents:

____

Consequences used:

____

Other Behavior: _______Yes _______ No

Frequency (daily, weekly, monthly) and Duration:

____

Antecedents:

____

Consequences used:

____

Self Stimulatory Behaviors:

Repetitive mannerisms (hand flapping, flicking, gazing, lining up objects, hoarding objects, toe walking, running back and forth etc.)

____

____

____

Unusual attachment to objects:

____

____

____

Repeating previously heard words out of context-echolalia:

____

____

____

Difficulty with transitions or changes in routine:

____
____
____

Unusual interest in the sight, feel, sound, or smell of things:

____
____
____

Unusual preoccupations/obsessions (anything he or she likes to do repeatedly):

____
____
____

Verbalizing in a repetitive manner (ie. “eee” sounds, babbling, screaming, etc.):

____
____
____

Social Behaviors:

Does your child show affection? How?

____
____
____

Does your child play with other children? If so, describe how.

____
____
____

Does your child play with toys? Is this appropriate or inappropriate?

____
____
____

Please list your child’s favorite toys, activities, music, food, games etc.

____
____
____

Does your child have good eye gaze/referencing abilities? How and with whom?

____

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____
____

Does your child respond to his or her name? ________ Yes _______ No

Does your child come to you for comfort? ________ Yes _______ No

Does your child respond better to any particular person? ________ Yes _______ No

To whom? ____

Does your child greet you in anyway when he or she sees you? _______Yes _______ No

How?____
____

Does your child show interest in other people? ________ Yes _______ No

How?____
____

Does your child attempt to involve you in something he or she is doing or get involved in something you or your family is doing? ________ Yes _______ No

Please describe some examples:
____
____
____

Language:

Did your child have speech that was lost? ________ Yes _______ No

If yes, at what age did he or she start to loose speech? ____________

What is your child's usual form of communication?
____
____
____

Any family history of developmental and/or speech/language disorders?
____
____
____

Does your child cry to let you know he or she wants something? ______Yes _______ No

Does your child take you or point to what he or she wants? ________ Yes _______ No
Does your child verbally communicate what he or she wants? ________ Yes _______ No

Receptive Skills:

Does your child follow verbal directions without given any visual cues? ___Yes___No
If yes please describe the complexity of the directions. (1-step, 2-step, with or without contextual cues, traveling to another location and returning with an item etc.)

____
____
____
____

Expressive Skills:

Does your child have any words? If yes please give examples.

____
____
____
____

Are the words your child uses in or out of context?

____
____
____
____

Does your child babble or combine sounds so that the combined sounds resemble some speech?

____
____
____
____

Are there any words that your child imitates? If so, please list them.

____
____
____
____

What is the average length of your child's utterances?

____
____

____
____

Are there problems with your child's articulation or intonation of speech?

____
____
____
____

Can your child hold a conversation about a favorite topic for any length of time?

____
____
____

Educational Background

Does your child attend school? ________ Yes _______ No

If yes, what school does your child attend? ____

What type of classroom does your child attend? (please include the methodologies that are utilized in the classroom)

____
____
____
____

How long has your child attended this school? ____

Does your child have an aide or shadow while attending school? (full or part time)

____
____
____
____

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):

____
____
____
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____
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____

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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
Appears to recognize that he or she can deliberately use his arms to reach for things, grasp things and reach his or her goals.			
Distinguishes between different facial expressions if you display them in an exaggerated way (e.g. smiles and frowns).			
Recognizes activities, songs and settings that he or she has experienced at least once before.			
Recognizes that he or she can try to repeat activities that have resulted in pleasure and enjoyment.			
Refrains from reaching for objects that are clearly out of reach.			
Deliberately makes vocalizations that are not accidental.			
Feels a special bond with parents and clearly treats them differently from other adults.			
Observes and imitates simple two-step actions.			
Visually tracks moving objects in his or her field of vision.			
Recognizes when others are attempting to communicate with him or her and shifts attention.			
Shows heightened awareness when other people approach or withdraw from him or her.			
Shows wariness and fear about taking actions that may cause harm to him or herself and/or others.			
Can participate in back-and-forth turn-taking interactions.			
Regulates the use of his or her hands and arms to reach goals: Pulling, pushing, grasping, turning etc.			
After observing you, he or she can remember to take two-step actions to reach desired goals.			
Follows your pointing and similar gestures to reach desired goals.			
Observes you to learn how to do new things and use objects.			
Recognizes that certain actions he or she takes will result in specific negative consequences.			

	Yes	No	Unsure
Unexplained and unpredictable emotional outburst			
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			
Tends to be clingy, whiny, cries easily			
Becomes easily disorganized			
Distractibility			
Can only focus on one thing at a time			
Tantrums			
Displays aggression toward self			
Displays aggression toward others			
Easily irritated			
Stubborn, inflexible, uncooperative			
Highly sensitive; problem taking criticism			
Gives up easily			
Easily scared. Indicate specific fears:			
Overly serious			
Not motivated to participate in adult-chosen activities			
Requires many prompts to complete familiar activities			
Uncomfortable holding an adult’s hand or with adult’s touch			
Hypersensitive to sounds			
Often seems confused about past, present and future, or about timing of events			
Restless, constantly moving, can’t sit still			
Becomes easily unsafe when playing or moving around			

	Yes	No	Unsure
Impulsive, does not seem to think before acting			
Frequently rubs eyes during tasks requiring visual attention			
Seems easily overwhelmed with homework (if age appropriate)			
Uncomfortable around crowds (stores, parties, restaurants, etc.)			
Loses interest quickly			
Has difficulty following daily home routines (refuses, tantrums, whines, requires many prompts, etc.)			
Picky eater			
Eating too slow or too fast			
Not properly using eating utensils			
Excessive spilling			
Problems with tooth brushing			
Difficulty fastening clothing (buttons, snaps, zippers, etc.)			
Discomfort with haircutting			
Takes a long time to get dressed			
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			
Trips and loses balance easily			
Poor handwriting			
Poor hand skills (coloring, cutting, writing, stringing beads, stacking Legos®, etc)			
Walks awkwardly			
Bumps into objects and/or people			
Does not alternate feet with stairs (if age appropriate)			
Clumsy or uncoordinated			
Poor speech articulation			

	Yes	No	Unsure
Difficulty getting along with peers			
Tends to control others during play			
Difficulty taking turns during play			
Difficulty falling asleep or staying asleep			
Slow to rise in the morning			
History of diarrhea			
History of constipation			
History of stomachaches			
History of vomiting			
History of headaches			
History of earache or ear infections			
History of allergies			

Please note your ideal number of sessions/hours for Speech Therapy, Occupational Therapy, and/or Tutoring Sessions:

Speech Therapy Sessions Per Week:____________________________

Occupational Therapy Sessions Per Week: ______________________

RDI® Consultation Sessions Per Week: ___________________________

Tutoring Hours Per Week: ______________________________________

Please note your ideal schedule for services and include which services per appointment:

Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
8-10							
10-12							
12-2							
2-4							
4-6							

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 along with your initial payment and your records to:

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

Thank you