

Child Registration Form

PLEASE PRINT

Name of Child _____

Birthdate _____

Parent's name

(Father) _____

DOB _____

(Mother) _____

DOB _____

Address _____

Contact Information

(Daytime) _____

(Evening) _____

(Father) Cell Phone _____

(Mother) Cell Phone _____

(Father) Email _____

(Mother) Email _____

Level of Education

(Father) _____

(Mother) _____

(School of Child) _____

Grade _____

Others living at home:

Name	Sex	Birth date	Age	School/Grade
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Father Employed by _____

Business Telephone _____

Gregory Keck, PhD
ABC of Ohio
12608 State Road, Suite 1
Cleveland, Ohio 44133
440-230-1960
www.abcofohio.net

Soc. Sec. # _____

Mother 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. _____

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: _____

With whom: _____
