APPLICANT'S HISTORY

Please type or print. If a question is not applicable, complete the blank with "n/a".
If additional space is required, please attach a separate sheet of paper.

APPLICANT INFORMATION

Child's Name_____
FIRST MIDDLE LAST PREFERRED

Date of Birth (mm/dd/yy) _____ Age: __Years __ Months Sex: ❒ Male ❒ Female

Address_____

City _____ State _____ Zip Code _____

Home Phone Number (_____)_____-_____ Cell Phone Number (_____)_____-_____

School Currently Attending _____ Grade____

By whom and for what reason(s) were you referred to Helping Hands Private Day School?

_____

Has this child applied to Helping Hands Private Day School in the past? ❒ Yes ❒ No
If yes, in what year?_____

FAMILY INFORMATION

Father (❒ Guardian)

FATHER'S FULL NAME AGE

HOME ADDRESS

CITY/STATE/ZIP

HOME PHONE WORK PHONE

CELL PHONE E-MAIL ADDRESS

OCCUPATION JOB TITLE

EDUCATIONAL BACKGROUND/DEGREES

Mother (❒ Guardian)

MOTHER'S FULL NAME AGE

HOME ADDRESS

CITY/STATE/ZIP

HOME PHONE WORK PHONE

CELL PHONE E-MAIL ADDRESS

OCCUPATION JOB TITLE

EDUCATIONAL BACKGROUND/DEGREES

HOME ENVIRONMENT

Child lives with (check all that apply) ❒ Father ❒ Mother ❒ Stepfather ❒ Stepmother

❒ Other Adults (please specify)_____

Explain any unusual custody arrangements _____

Person financially responsible for the child _____

Correspondence should be sent to _____

Sibling(s): (List all children, beginning with the oldest)

NAME	*AGE*	*GRADE*	*SPECIAL DIFFICULTIES, IF ANY*

Describe difficulties that father, mother, or other relatives had in their educational or psychological history_____

_____

_____

Are parents receiving any special counseling? ❒ Yes ❒ No If yes, from whom? _____

PLACES CHILD HAS LIVED	*DATES*

Is the child adopted? ❒ Yes ❒ No If yes, at what age? _____ Location _____

Languages spoken in home: English ❒ Yes ❒ No Other: _____

Religious Preference (The answer to this question is helpful for planning but not required) _____

Describe the child's relationship to his/her:

Father _____

Mother _____

Siblings _____

Teachers _____

Peers _____

Who disciplines the child, and how? _____

_____

MEDICAL HISTORY

Birth & Early Development

Length of pregnancy _____ ❒ Weeks ❒ Months Length of Labor _____hours ❒ C-section

Significant illness or accidents during pregnancy _____

Describe anything unusual about the delivery _____

Have developmental milestones been age appropriate. ❒ Yes ❒ No

If no, explain, _____

Describe any chronic medical condition, including allergies _____

_____

List operations, serious illnesses, or injuries with approximate dates _____

_____

Name any undiagnosed seizure conditions, describe activity and give most recent date

_____

Current Development

Pediatrician or Family Physician _____

Address _____ Phone _____

Date of last physical exam _____ Significant Results _____
Date of last hearing test _____ Examiner _____
Describe any auditory problems _____
Date of last vision test _____ Examiner _____
Describe any vision problems _____
If child wears glasses, when are they to be worn? _____

Medication (List all medication **presently** prescribed for child.)

MEDICATION	*DATE BEGUN*	*CONDITION BEING TREATED*	*PRESCRIBING PHYSICIAN*

Medication previously used by child and significant condition treated _____

_____

Are your child's eating habits ❒ Good ❒ Average or ❒ Poor?

Does your child sleep ❒ Restfully or ❒ Restlessly?

Describe if your child shows any of the following types of behavior at home or at school. Check "H" for home; "S" for school, and "B" for both home and school.

	H	S	B		H	S	B		H	S	B
Temper Tantrums	❒	❒	❒	Shyness	❒	❒	❒	Physical Aggressiveness	❒	❒	❒
Stuttering	❒	❒	❒	Nervousness	❒	❒	❒	Difficulty sleeping	❒	❒	❒
Nail Biting	❒	❒	❒	Prevaricates	❒	❒	❒	Highly Distractible	❒	❒	❒
Awkwardness	❒	❒	❒	Thumb Sucking	❒	❒	❒	Hyperactivity	❒	❒	❒
Defiance	❒	❒	❒	Poor Memory	❒	❒	❒	Clings to objects	❒	❒	❒
Daydreams	❒	❒	❒	Exaggerates	❒	❒	❒	Other _____	❒	❒	❒

EDUCATIONAL HISTORY

Schools attended. (List all schools, beginning with the most recent.)

SCHOOL	DATES ATTENDED	GRADE LEVEL(S)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Was your child's entrance into kindergarten delayed? ❒ Yes ❒ No

Has the child been kept back at any grade level? ❒ Yes ❒ No

If yes, which level and why _____

Is your child currently receiving Special Education services? ❒ Yes ❒ No

If yes, what is the Disability Classification? _____ Amount of Service _____

Does your child have a current IEP? ❒ Yes ❒ No

Does your child have a current 504 Plan? ❒ Yes ❒ No

Has he/she received Special Education services in the past? ❒ Yes ❒ No Dates _____

Please check any areas of difficulty for your child:

❒ Speech ❒ Reading ❒ Arithmetic ❒ Writing ❒ Spelling ❒ Fine Motor

❒ Gross Motor ❒ Attention ❒ Organization ❒ Work/Study Habits ❒ Time Management

BEHAVORIAL INFORMATION

How does your child communicate with you/adults? (Form of communication)

_____

How does your child communicate with peers/siblings? (Form of communication)

_____

Please provide any additional insight into the way your child communicates

_____

Does your child engage in problem behaviors? _____ If yes, please describe:

_____

Under what conditions does the behavior occur? _____

_____

What situations/interactions have been used in the past? (effective and not effective)

_____

Is your child afraid of anything? If yes, please describe _____

_____

How would you describe your child?

❒ Usually very active	❒ Can be moody	❒ Lacks confidence in self
❒ Active sometimes, but can play quietly	❒ Demands excessive attention	❒ Enjoys playing with other
❒ Usually not active, has to be prompted	❒ Aggressive towards self or others	❒ Prefers motor activities
❒ Usually happy	❒ Short attention span	❒ Prefers sit-down activities

DIAGNOSTIC INFORMATION

Please complete applicable items.

Date of most recent **educational evaluation**_____ Examiner_____

Address _____ Phone _____

Date of most recent **psychological evaluation**_____ Examiner_____

Address _____ Phone _____

Date of most recent **neurological evaluation**_____ Examiner_____

Address _____ Phone _____

Date of most recent **psychiatric evaluation**_____ Examiner_____

Address _____ Phone _____

Date of most recent **speech/language evaluation**_____ Examiner_____

Address _____ Phone _____

Date of most recent **occupational therapy evaluation**_____ Examiner_____

Address _____ Phone _____

SERVICES

Please complete the following information for professionals currently working with your child. (Include tutors, therapists, psychiatrist, psychologist, etc.)

SERVICE PROVIDED	NAME OF PROVIDER	FREQUENCY

Please complete the following information for professionals who have worked with your child in the past. (Include tutors, therapists, psychiatrist, psychologist, etc.)

SERVICE PROVIDED	NAME OF PROVIDER	FREQUENCY

NEEDED ACCOMMODATION(S)

Describe any needed accommodation(s) the child needs in daily activities and why:

Diet or Feeding: _____

_____

Toileting: _____

_____

Transportation: _____

_____

Other: _____

_____

Additional Comments: _____

_____

APPLICANT'S INTEREST

Describe your child's hobbies _____

_____

List the kinds of games and recreation your child enjoys _____

_____

Does your child prefer to play with children ❒ His/her own age ❒ Younger or ❒ Older?

Does your child enjoy playing alone? ❒ Yes ❒ No

With adults? ❒ Yes ❒ No With a group of children? ❒ Yes ❒ No

Please describe _____

Approximate number of hours per week your child watches T.V. _____

Favorite T.V. programs _____

What are his/her favorite items?_____

_____

Does your child read independently for pleasure? ❒ Yes ❒ No

Favorite books _____

_____

Describe your child's musical interests_____

_____

What kind of recreational activities does your child seem to enjoy the most?

_____

_____

_____

List your child's participation in school or community organizations or activities

SERVICE PROVIDED	NAME OF PROVIDER	FREQUENCY

Describe your child's regular home responsibilities, if any _____

_____

Comment on his/her attitude and regularity of performance _____

_____

Please make any other comments which you feel would be helpful to us in knowing and working with your child (Continue on an additional sheet if necessary.)

This form completed by _____

Relationship_____ Date _____

If applicable, please provide work samples and progress reports from school, including: a raw writing sample, list of recent reading material, samples of math activities and/or a list of math curriculum topics recently covered. Please also provide a brief written assessment of your child's academic strengths and weaknesses as you perceive them, and a summary from your child's current teacher.

Please include any IEP, testing from school systems, testing from private facilities, doctor's recommendations, etc.

If there is any additional information that you feel we should know please include on a separate piece of paper with your application.

Thank you for your interest in Helping Hands, Inc.

HELPING HANDS
PEDIATRIC THERAPY SERVICES

2049 Jefferson Davis Hwy ✦ Stafford, VA 22554
540.657.1423 ✦ 540.657.1424 (fax) ✦ www.hhitherapy.com