

Multidisciplinary THERAPY



1634 Taylor St.
Columbia, SC 29201
Phone: (803)410-5483
Fax: (803)250-2651

Patient Information Form ABA THERAPY

Patient's Name (as appears on insurance card): _____

DOB: _____ Male Female

Address: _____

Email: _____

Cell Phone Number: _____ Phone Number: _____

Diagnosis (if known): _____

Primary Physician: _____

Physician's Phone and Address: _____

How did you hear about Multidisciplinary Therapy Inc.? _____

Insurance Info

Primary Ins: _____ Name of Ins: _____

Insured Social Security: _____ DOB: _____

Member ID #: _____ Group#: _____

Customer Service phone: _____

Claims Address (found on back of card): _____

Name: _____ Phone: _____

Consent to Treat

I, (parent/guardian name) _____, consent for Multidisciplinary Therapy to provide (patient name) _____, with a ABA Therapy evaluation and subsequent therapy services. I consent to care and treatment falling under the practice guidelines of America and the State of South Carolina. I acknowledge that there is always a risk of injury with any therapy involving physical activities.

Signature: _____

Printed Name: _____

Date: _____

Permission for Exchange of Information

I authorize Multidisciplinary Therapy, Inc. to release necessary and pertinent medical information to physicians, case managers, BCBA's and insurance companies as needed.

Approved information may be exchanged with the following people directly related to the patient's care: Therapists School Officials Other: _____

Signature: _____

Printed Name: _____

Date: _____

Supervision Consent for BaBA Supervision

Supervisor:

- Name: Cierra Stewart, BCBA
- Contact Information:
- (803) 795-1976
- cierra@scbehaviorco.com

Supervisee:

- Name: Tristan Pack, BCaBA
- Certification Number: BCaBA 0-23-14725
- Contact Information:
- (803) 983-7143
- tpack.mdt@gmail.com

Purpose of Supervision

I, Tristan Pack, am currently a Board Certified Assistant Behavior Analyst (BCaBA) and acknowledge that I will be receiving supervision from Cierra Stewart, a Board Certified Behavior Analyst (BCBA). The purpose of this supervision is to ensure compliance with the Behavior Analyst Certification Board (BACB) standards and guidelines, to provide support and guidance in the application of applied behavior analysis (ABA), and to foster professional development and skill acquisition. You can find out more about this certification at <https://www.bacb.com>.

Purpose of Information Release

As a Board Certified Assistant Behavior Analyst (BCaBA), I, Tristan Pack, am required to be supervised by a Board Certified Behavior Analyst (BCBA) for at least 2% of my total direct hours as per BACB standards. This supervision ensures that the services I provide align with the professional and ethical standards set forth by the Behavior Analyst Certification Board (BACB).

To facilitate this supervision, I am requesting consent to share relevant client information with my BCBA supervisor, Cierra Stewart.

Purpose of Release

The purpose of releasing this information is to ensure that services are delivered in accordance with the professional and ethical standards established by the Behavior Analyst Certification Board (BACB), and to provide the BCBA with adequate oversight to maintain the quality of services.

Duration of Consent

This consent will be valid for one year from the date of signature, or until I, Tristan Pack, take and pass the BCBA examination, whichever occurs first

Revocation of Consent

You have the right to revoke this consent at any time by providing a written request to Tristan Pack. Revoking this consent will not affect any actions taken before the revocation.

Information to Be Released

The following client information may be shared with the supervising BCBA:

- Treatment plans
- Progress reports
- Data and session notes
- Any additional information required for effective oversight of the case

Scope of Supervision

Supervision will include but is not limited to:

- Review and guidance on assessments and interventions.
- Observation of direct implementation of ABA programs.
- Feedback on data collection and analysis.
- Discussions of ethical and professional practice.
- Review of case studies, client progress, and treatment planning.

Supervision will be conducted in accordance with the BACB's guidelines and requirements for BCaBA supervision.

Methods of Communication

All client information will be shared between the BCaBA and the BCBA using secure, password-protected, and HIPAA-compliant electronic medical record (EMR) systems to ensure confidentiality and data security.

Confidentiality:

All information shared during supervision will be kept confidential between the supervisee and the supervisor, except in cases where there is an obligation to disclose information by law (e.g., concerns about client welfare or ethical violations).

Consent

I, the undersigned, give my consent for the release of the above-specified client information to [BCBA Name] for the purpose of effective supervision of [BCaBA Name]. I understand the purpose of this release and my right to revoke consent.

Client/Parent/Guardian Signature: _____

Date: _____

Signatures:

Supervisee (BCaBA):

Date: 9/25/24

 _____

Supervisor (BCBA):

Date: 9/25/24

 _____

Absences and Cancellations

Multidisciplinary Therapy, Inc. strives to provide the highest quality of care while attempting to accommodate each patient's schedule. Therefore, we provide each patient a reserved time slot with a specific therapist in order to minimize wait time and assure continuity of treatment. Consistent attendance and adherence to the planned treatment regimen is paramount to your child's success in therapy.

While we are sensitive to the fact that an emergency may occur, cancellations, tardiness and absenteeism reduces our ability to accommodate the scheduling needs of our patients. As such, we request your full cooperation with the following company policy:

- Each patient is given 2 appointments to miss within a 1-month period. For a missed appointment to not count against a patient the missed session must be made up by the end of the month the appointment was canceled.
- Any missed session not made up by the end of the month will count as a missed appointment. Fridays are available to schedule make-up appointments with your child's therapist.
- If more than 4 sessions are missed within a 2-month period without making up the missed appointments, this may result in the **DISCHARGE** of the patient.

All cancellations and absences will be documented in your child's therapy record and reported to your physician and insurance company or third party payer.

Your insurance requires your child to improve while receiving services. If your child frequently misses scheduled therapy appointments, your insurance will not approve additional visits due to a lack of progress associated with missed visits, which will result in your child being discharged from treatment.

Signature: _____

Printed Name: _____

Date: _____

Late Pick-Up Policy

Please be aware of the following policy regarding late pick-ups from sessions:

- **First Late Pick-Up:** Verbal alert
- **Second Late Pick-Up:** Parent/guardian must remain on site during session(s)
- **Third Late Pick-Up:** Patient discharged from services

Sessions generally last 50-150 minutes. If your child's appointment end time is at 2:00, for example, a parent/guardian needs to be back at the facility by 1:50.

It is essential for your timely return as the therapist must consult with you regarding the treatment session and provide at home recommendations.

Parent/Guardian Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact Multidisciplinary Therapy at (803)410-5483.

Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you with a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures

The following categories describe how we may use and disclose your medical information.

For Treatment: We may use health information about you to provide you treatment or services. This means providing, coordinating, or managing health care and related services by one or more health providers. An example of this would include a physical examination.

For Payment: We may use and disclose health information about your treatment and services for such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

For Health Care Operations: Members of our staff may use information in your health record for the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may disclose information to students for educational purposes. We may remove information that identifies you from this set of health information to protect your privacy. We may contact you to remind you that you have an appointment; assess your satisfaction with our services; tell you about possible treatment alternatives; tell you about health-related benefits or services; and we may leave messages on your answering machine or voice mail regarding primary appointment reminders and billing/collections efforts.

Future Communications: We may contact you in the future via newsletters, mail outs, or other means regarding treatment options, health related information, or other community based initiatives or activities our facility is participating in.

Organized Health Care Arrangement: This facility and its staff members have organized and carry out treatment, payment, and healthcare operations. Therapists and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Law Enforcement/Legal proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written

request, except to the extent that we have already taken actions relying on your authorization.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

Inspect and Copy: You have the right to inspect and obtain a copy of your health information, including billing records.

Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our facility. Any request for an amendment must be sent in writing to the Facility Privacy Official.

An Accounting of Disclosures: You have the right to request and accounting of disclosures. This is a list of certain disclosures we make of your health information for purpose other than treatment, payment, or healthcare operations where an authorization was not required.

Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care (i.e., family member or friend). Any request for a restriction must be sent in writing to the Facility Privacy Official. We are required to agree to your request only if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose related to payment of health care operations (and not treatment purposes), and 2) your information pertains solely to health care services for which you have paid in full. For other requests, we are not required to agree. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we contact you at work instead of at home or in a private room, rather than in the waiting room. The facility will grant requests for confidential communication at alternative locations and/or alternative means if the request is submitted in writing and the written request include a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

A Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Changes to This Notice

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with this facility. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you and documented in our facility.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Provide treatment and services
- Bill and collect payment from you, your insurance company, or a third party payer
- Conduct healthcare operations such as assess my care and outcomes as well as quality assessments

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of my rights and the uses and disclosures of my health information. I understand that Multidisciplinary Therapy, Inc. has the right to change its Notice of Privacy Practices and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Multidisciplinary Therapy, Inc. restricts how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that this organization is not required to agree to my requested restrictions, but if the organization does agree then it is bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Financial and Insurance Policy

- A copy of your driver's license and insurance information is required before services begin. Benefits will be verified upon receipt of your insurance information and you will be made aware of any **estimated** out-of-pocket expenses before any services are started. Information obtained from insurance companies is **not always a guarantee of payment**. Families are ultimately responsible for payment for non-covered services. It **is imperative that families are aware of their insurance coverage and their potential responsibilities**. We will strive to keep open communication in regards to insurance and payment. Families will inform Multidisciplinary Therapy, Inc. of any changes regarding insurance. Families assign benefits for filed claims to be paid to Multidisciplinary Therapy, Inc. Any payment sent directly to the family, intended to cover therapy services provided by Multidisciplinary Therapy, Inc., should be given promptly. parent initials

- If a patient has private insurance, a credit card is required to be on record prior to the patient's first appointment. _____parent/patient initials

- The usual and customary rate for services is billed to insurance. If we bill your insurance and you have a deductible, **the full amount applied to your deductible will be billed to you**. We do accept Medicaid and private insurance for ABA therapy services and responsibilities are determined by plan. Multidisciplinary Therapy, Inc. accepts cash, and check, there is a \$50 fee for all returned check.

_____parent initials

- We submit claims to insurance within one month of service dates. If payment has not been received within 60 days, the family will be responsible for the balance. If insurance makes payment, the family will be reimbursed any money that was paid for these services. If a family receives a bill that is not paid within 30 days of receipt of invoice, there will be a **10% late fee** added, and services risk being put on hold.

_____parent initials

- Multidisciplinary Therapy, Inc. will file all **ABA Therapy** claims per our agreements with each insurance company. Please contact us to get an updated list of companies with whom we are in network. If authorization is required, therapists will submit based on need. Services will be administered after approval has been obtained.

_____parent initials

- For parents requesting to pay out of pocket, an initial evaluation for **ABA Therapy** services is \$120/hour. An initial evaluation will be needed for all children starting therapy with our facility. Most evaluations will last 1 hour. For parents requesting to pay out of pocket for therapy services, it is \$100/hour and \$60/half hour. If a family needs a re-evaluation for insurance or personal reasons, the rate will be \$100/hr. Financial arrangements will be made prior to the time of evaluation. parent initials

Signature: _____

Printed Name: _____ **Date:** _____

SERVICES OFFERED

We will provide services specifically designed to help you (and/or your minor child), or otherwise provide you with referrals to other professionals. Our behavioral services consist primarily of individual assessments (behavioral evaluations), training, in-home and in-school consultations and observations, long-term ABA service provision to individuals diagnosed with autism spectrum disorder, and short-term consultations with individuals, parents, educators, and other related professionals.

Steps to Begin ABA Services

Complete and return the intake packet:

1. If Insurance is involved, pre-approval is required prior to evaluation, therapy, or other service.
2. Intake Assessment with BCaBA (typically 1-2 hours) to evaluate, assess, interview, and complete any other necessary paperwork prior to writing the treatment plan
3. Meeting to review behavior plan.
4. Arrange a regular schedule for ABA.

What to expect:

A typical ABA session:

- is completely positive
- focuses on skill acquisition and/or behavior reduction
- is individually designed to meet each child's unique needs
- focuses on motivation to learn
- uses the most-effective, evidence-based treatment approach

Individualized Behavior plans focus on:

- Remediating deficits related to diagnosis, including:
- increasing important, socially significant behaviors
- increasing communication skills including verbal behavior and social skills
- increasing play behaviors
- increasing self-help and adaptive skills
- increasing skills so that the child can interact with and function as same-age peers
- decreasing behaviors that impede the ability to learn

Treatment is closely monitored using data to make appropriate treatment decisions in collaboration with parents and/or caregivers. Treatment plans are updated and submitted to insurance and care providers every 6 months.

In addition to the individual's program, we also schedule REQUIRED parent training sessions at intervals throughout the duration of the individual's time in therapy. These sessions are typically required and covered by insurance plans.

These sessions are provided to address behaviors in- home and focuses on increasing skills and decreasing problem behaviors in all environments using state-of the-art behavior interventions.

Behavioral assessment, parent training, program supervision, and quality monitoring are all part of each program and is supervised by the BCaBA and supervising BCBA.

Information Related to Scheduling and Sessions

- Each case is under the supervision of Tristan Pack, BCaBA, acting under the supervision of Cierra Stewart, BCBA. You can find out more about this credential at www.bacb.com.
- Therapy Sessions can range anywhere from 1-4+ hours each day, depending on the unique needs of each client. Research is clear that consistent sessions result in better outcomes and make scheduling more convenient for all parties. If this is not convenient, please let the BCBA know at your next appointment.
- For in clinic services, patients may be left at therapy and picked up at the designated time. However, they **MUST** be picked up and signed in by a parent or designated caretaker. For sessions in the home, a parent or guardian must be present in the home for the entire duration of the session.
- Families must give at least 2-weeks' notice on significant changes in their plans for ABA session scheduling in order to facilitate consistency in service delivery. Failure to do so may result in dismissal from therapy.
- The standard therapy hour consists of 45-50 minutes of direct contact with the client and 10-15 minutes devoted to required record-keeping and other administrative duties. It usually takes 10-15 minutes to arrange the materials and set up for sessions prior to engaging with the client. It also takes about 10-15 minutes at the end of the session to record data, take notes, tidy the setting, and discuss the session and/or answer questions with parents.

Informed Consent

Informed Consent Client Name: _____ DOB: _____

I, _____, agree to have my child evaluated/treated through Multidisciplinary Therapy I understand that these services are based on an applied behavior analysis (ABA) model and will be provided by a professional trained in ABA. I understand that state laws may require that confidentiality be broken under certain circumstances, specifically, if I am judged by the behavior analyst to be of danger to myself and/or others, gravely disabled, or if there is suspected child abuse.

I also understand that Multidisciplinary Therapy specializes in the evaluation and treatment of problem behaviors, as well as, skill acquisition, and if Multidisciplinary Therapy is unable to meet my particular needs, I will be referred to an appropriate agency or individual.

Services: Multidisciplinary Therapy Implements Applied Behavior Analysis for its services. A variety of techniques are integrated and utilized during treatment. You will be encouraged to practice various skills introduced in sessions. A treatment plan with specific goals will be explored and updated according to treatment plan schedules. Recommendations for additional treatment and/or intensive treatment may be made if needed. When a client is a minor under the age of 14, parent involvement is required during all visits with the Client. Information will be limited to accommodate confidentiality with children of all ages. Family involvement is an important part of treatment. Children under the age of 18 will require a parent's signature (or legal guardian) to receive any form of treatment.

Concerns about services may be directed to the Multidisciplinary Therapy

Administration. Client's Name: _____ DOB: _____

Parent or Guardian Signature: _____ Date: _____

Parent or Guardian Name: _____ Date: _____

DEVELOPMENTAL HISTORY

PRENATAL HISTORY:

Pregnancy: # of Weeks _____
Normal/Problems (describe): _____
Birth Weight: _____ Apgar Score: _____
Labor: Normal/Induced _____ Special Considerations: Cesarean _____
Premature _____ Breech _____ Child Rotated _____
Cord Around Neck _____ Other _____
Hospital Stay: Mother _____ Child _____
If child was adopted, please give as much information as possible about the child's biological mother and family history: _____

DEVELOPMENTAL MILESTONES

At what age did your child:
Sit up without support _____ Crawl _____ Walk _____
Run _____ Use Words _____ Speak in sentences _____
Drink from a cup _____ Use spoon, fork, knife _____ Dress self _____

MEDICAL HISTORY

Does your child have any allergies? _____
Is your child currently taking any medications regularly or as needed? _____

Does your child have a history of ear infections? _____

Has your child had his/her hearing tested? _____
Results? _____

Has your child had a visual exam? If so, when and what were the results? _____

Has your child received a medical diagnosis/diagnoses from any other health care professional(s)? _____

Is your child currently receiving any other special services through school or privately? (physical therapy, speech therapy, psychology, tutoring - please list names of other professionals) _____

Who is your child's pediatrician? _____

Which hand does your child show dominance? _____

Does your child have a history of seizures? _____

Does your child have any current health conditions (diagnosed) other than Autism? _____

Is your child currently taking any medications?

* If yes, please provide the following information:

Name of Medication	Amount	How often is the medication taken	When is the medication taken	Please state any reactions/ side effects your child experiences from the medication

Does your child/adolescent currently have a diagnosis? _____

* If yes, please provide the following information: _____

Diagnosis	Diagnosing Physician	Date Diagnosed	Level (1,2,3)	Diagnosis Code

Please note that the diagnosis information is required for insurance coverage. By having this information, it assists us when speaking with your insurance company to get authorization for services and providing you with invoices for reimbursement through insurance.

EDUCATIONAL HISTORY

What is your child's current grade? _____

Teacher's Name: _____

What school does he/she attend? _____

Please list other school attended. _____

Does your child have an Individualized Education Plan (IEP)? _____

Has your child's teacher reported any concerns? _____

Is your child/adolescent currently classified for special education services? _____

FAMILY BACKGROUND

Do both parents currently live in the home?

* If divorced, who has legal custody? Is it full or joint custody?

Are there siblings?

If yes, please provide the following information:

	Name	Age	Relationship	Living in Home?
1.				<input type="checkbox"/> Yes <input type="checkbox"/> No
2.				<input type="checkbox"/> Yes <input type="checkbox"/> No
3.				<input type="checkbox"/> Yes <input type="checkbox"/> No

Please indicate and describe whether any of the siblings have any special needs, diagnoses, or concerns.

Are you also interested in seeking services for any of the siblings with special needs?

Yes No Not applicable

*If yes, you will need to complete a new intake packet for that child.

Are there any other individuals residing in the house or that play a significant role on how this child is raised?

Yes No

* If yes, please identify who else is involved in raising the child and their relationship to the child.

BEHAVIOR / SOCIAL

Describe your child's social interaction with other children.

Describe your child's tolerance for challenging or frustrating tasks.

How does your child do when making transitions between activities, environments, or when there are unexpected changes in plans/expectations?

Does your child tend to play alone, with other children, or performs both equally?

Describe tasks which your child finds challenging or frustrating and how he/she tolerates such tasks.

What are your child's strengths?

What are your child's favorite items and/or activities?

Please indicate if your child/adolescent engages in any of the following behaviors (check all that apply):

- Aggression (specify below)
 - Hitting (e.g., punch, slap, etc.)
 - Kicking
 - Biting
 - Pinching
 - Head-butting
 - Scratching
 - Spitting
 - Other (Please specify): _____
- Self-Injurious Behavior (specify below)
 - Hitting self with hands or fists (Where on body? _____)
 - Kicking self (Where on body? _____)
 - Biting self (Where on body? _____)
 - Head-butting walls, windows, etc.
 - Pulling teeth
 - Scratching skin
 - Cutting/burning
- Other (Please specify): _____
- Property Destruction (describe: _____)
- Eloping (i.e., running out of a building, room, vehicle, etc.)
- Sensory issues (describe: _____)
- Difficulty with toileting
- Defiance or problems with authority
- Problems with eating
- Tantrums
- Screaming/yelling
- Vocalizations
- Repetitive behaviors
- Other (Please specify): _____

How are your child's communication skills?

What are some of the goals you have for your child while receiving ABA treatment?

For the behavior you want to decrease (maladaptive) how would you start and stop the behavior? If you were given a million dollars to turn the behavior on and off, how would you do it?

What is typically used for disciplining your child (e.g., timeout, assigning chores, etc.)?

Are there any spiritual beliefs or values that you think may impact how you provide discipline or behavioral supports to your child? Yes No

* If yes, please describe below.

Are there any cultural beliefs or values that you think may impact how you provide discipline or behavioral supports to your child? Yes No

* If yes, please describe below.

SELF-CARE / DAILY ROUTINES

Please describe your child's eating habits (include # of meals, # of snacks, food likes/dislikes).

If your child is experiencing feeding problems, please provide additional information. (e.g. foods your child eats regularly).

Foods your child used to eat but no longer eats.

Are there sensitivities to taste? Explain.

Are there sensitivities to texture? Explain.

Are there sensitivities to temperature? Explain.

Please describe your child's sleep habits (include bedtime routine, # of hours, # of naps, if any).

Please describe how your child typically gets dressed. (Include how much assistance is needed, length of time, preference for certain fabrics/avoidance of textures).

Can your child fasten snaps? _____ buttons? _____ zippers? _____
Buckles? _____ Velcro enclosures? _____
Tie shoes? _____ Put on shoes? _____

Please describe bath time for your child (level of independence, like/dislike, preference for a bath or shower)

Please describe your child's ability/tolerance of:

Brushing teeth: _____

Brushing hair: _____

Washing hands/face: _____

Is your child toilet trained? _____ If so, when did this occur? _____

Please describe if there were/are any problems with toileting.

Please describe your child's ability to keep track of personal belongings.

ATTENTION / SELF-REGULATION

Does your child have a difficult time calming down to go to sleep or waking up in the morning? If so, please explain.

Is your child irritable at predictable times of the day? If so, what events trigger this and when does it occur?

Does your child seem happier or more cooperative at predictable times of the day? Please describe.

Does your child exhibit any impulsiveness, aggression, or immaturity more than other

children his/her age? If so, please explain.

Describe your child's ability to attend to activities (e.g. responding to his/her name or a question in a timely manner, table top tasks -vs- gross motor activity -vs- homework).

EYE contact and appropriateness to situation

MOTOR SKILLS

Please describe your child's fine motor and visual motor skills (manipulation of small objects and toys/ dexterity, grasp on pencils/crayons, control/accuracy, quality of writing). Please do not leave this area blank

Please describe your child's gross motor skills (balance, coordination, jump/hop/gallop/skip, endurance, strength). Please do not leave this area blank.

Can your child ride a bicycle (tricycle or two wheeler)? Please describe.

Please describe how your child ascends and descends stairs (alternates feet, holds rail, etc.).

Please describe your child's performance on jungle gym type equipment (preferences, tolerance for swings, climbing, level of independence).

Describe your child's play skills. Include his/her interests, favorite toys/games, pretend themes used in play, etc.

Does he/she use toys the same way each time play occurs, or is his/her play constantly changing and evolving? Please describe.

Parental Concerns

Please share any other information you would like us to know about your child/family.
