RIDGEFIELD SENSORY CLINIC
PHYSICAL • OCCUPATIONAL • SENSORY

Ridgefield Sensory Clinic, LLC
79 Danbury Road, Suite A1
Ridgefield, CT 06877
203-894-5230
ridgefieldsensoryclinic@gmail.com
ridgefieldsensoryclinic.com

PATIENT REGISTRATION INFORMATION

Client Information:

LAST NAME:_____ FIRST NAME:_____ MI:_____

NICKNAME:_____ DOB:_____ GENDER: ☐ M ☐ F

Parent Information:

Mother

LAST NAME:_____ FIRST NAME:_____ MI:_____

DOB:_____ E-MAIL:_____

HOME PHONE:_____ LEAVE MSG? ☐ Y ☐ N

CELL PHONE:_____ LEAVE MSG? ☐ Y ☐ N

OTHER PHONE:_____ LEAVE MSG? ☐ Y ☐ N

ADDRESS:_____
#/STREET CITY STATE ZIP

Father

LAST NAME:_____ FIRST NAME:_____ MI:_____

DOB:_____ E-MAIL:_____

HOME PHONE:_____ LEAVE MSG? ☐ Y ☐ N

CELL PHONE:_____ LEAVE MSG? ☐ Y ☐ N

OTHER PHONE:_____ LEAVE MSG? ☐ Y ☐ N

ADDRESS:_____
#/STREET CITY STATE ZIP

SIBLINGS (NAMES, AGES, GENDER):_____

PETS (NAMES & TYPE OF ANIMAL):_____

EMERGENCY CONTACT (not living in household)_____

PHONE:_____ RELATIONSHIP TO CHILD:_____

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PT/OT HISTORY FORM

CLIENT NAME:_____ DATE:_____

DIAGNOSIS (ES):_____

CHIEF CONCERNS:_____

SYMPTOMS:_____

WHAT ARE YOUR GOALS FOR THERAPY?_____

_____

HAS YOUR CHILD RECEIVED THERAPY IN THE PAST? IF YES, WHAT KIND, WHERE, AND RESULTS:_____

_____

_____

REFERRING PHYSICIAN:_____ PHONE:_____

OTHER PHYSICIANS AND THEIR INVOLVEMENT IN CARE:_____

_____

BIRTH INFORMATION:

FULL TERM: ☐ PREMATURE: ☐ GESTATIONAL WEEKS:_____

BIRTH WEIGHT:_____ VAGINAL: ☐ C-SECTION: ☐

PREGNANCY OR DELIVERY COMPLICATIONS (NICU, oxygen, etc.):_____

_____

_____

PLEASE LIST ANY MEDICATIONS USED DURING PREGNANCY_____

_____

ANY MEDICAL PROCEDURES BEFORE OR AFTER BIRTH?

_____

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CHECK ALL THAT APPLY. PROVIDE AGE AND COMMENTS IF APPROPRIATE.

MEDICAL HISTORY

CONDITION	CHECK	AGE	COMMENTS
ALLERGIES	☐		
ASTHMA	☐		
CHRONIC ILLNESSES	☐		
DIFFICULTY EATING	☐		
DIFFICULTY SLEEPING	☐		
EAR INFECTIONS	☐		
HEARING EXAM/DIFFICULTIES	☐		
HEARING AIDS	☐		
PE TUBES	☐		
VISION EXAM/DIFFICULTIES	☐		
GLASSES or CONTACTS	☐		
HEART DISORDERS	☐		
SEIZURES/CONVULSIONS	☐		
STOMACH/INTESTINAL DISORDERS	☐		
INJURIES	☐		
HOSPITALIZATIONS	☐		
SURGERIES	☐		
ASSISTIVE DEVICES	☐		
OTHER	☐		

PLEASE LIST ANY MEDICATIONS BEING TAKEN:_____

_____

_____

ANY OTHER MEDICAL HISTORY WE SHOULD BE AWARE OF:_____

_____

_____

_____

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DEVELOPMENTAL HISTORY

CONDITION	CHECK	AGE	COMMENTS/CONCERNS
ROLLING OVER	☐		
SITTING	☐		
CRAWLING	☐		
STANDING	☐		
WALKING	☐		
RUNNING	☐		
ANY CONCERNS?	☐		
SELF CARE			
TOILET TRAINED (DAY)	☐		
TOILET TRAINED (NIGHT)	☐		
LIKES BATH	☐		
DRESSES SELF	☐		
BRUSHING HAIR	☐		
BRUSING TEETH	☐		
ANY CONCERNS?	☐		
SPEECH RELATED			
STARTED BABBLING (DADA, BABA, …)	☐		
USING WORDS (SINGLE)	☐		
COMBINING WORDS	☐		
PRONOUNCE WORDS CORRECTLY	☐		
HOW MANY WORDS DOES HE/SHE KNOW	☐		
ANY CONCERNS?	☐		
FEEDING			
FEEDING SELF	☐		
POOR SUCK	☐		
DIFFICULTY SWALLOWING	☐		
DIFFICULTY CHEWING	☐		
GAG OR CHOKE FREQUENTLY	☐		
DROOLING	☐		
PICKY EATER?	☐		
SENSITIVE TO CERTAIN FOOD TEXTURES	☐		
DRINK FROM SIPPY CUP	☐		
DRINK FROM OPEN CUP	☐		
ANY CONCERNS?	☐		

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DEVELOPMENTAL HISTORY (con't)

ACTIVITIES	CHECK	AGE	COMMENTS/CONCERNS
COLORING	☐		
WRITING	☐		
PLAYING WITH TOYS	☐		
DIFFICULTY SITTING IN CHAIR	☐		
CLUMSY	☐		
DIFFICULTY WITH STAIRS	☐		
OVERALL GENERAL WEAKNESS	☐		
HAND PREFERENCE	☐		

SENSORY HISTORY

CONDITION	CHECK	COMMENTS/CONCERNS
OVERLY SENSITIVE TO TOUCH?	☐	
FEAR ANYTHING	☐	
SENSITIVE TO CERTAIN SOUNDS	☐	
NOT HEAR CERTAIN SOUNDS	☐	
REFUSES TO WEAR CERTAIN CLOTHING	☐	
OVERLY DISLIKE GETTING MESSY	☐	
OVERLY DISLIKE FACE WASHING	☐	
OVERLY DISLIKE BRUSHING	☐	
SPIN OR ROCK	☐	
HIT SELF	☐	
DIFFICULTY MAINTAINING EYE CONTACT	☐	
CLOSE ONE EYE TO LOOK AT SOMETHING	☐	
TIP HEAD TO LOOK AT SOMETHING	☐	
ANY CONCERNS?	☐	

IS THERE A FAMILY HISTORY OF ANY OF THE FOLLOWING:

- ☐ LEARNING DISORDERS
- ☐ EMOTIONAL DISORDERS
- ☐ GENETIC DISORDERS
- ☐ ATTENTION DISORDERS
- ☐ SPEECH/LANGUAGE DISORDERS
- ☐ SUBSTANCE ABUSE

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SOCIAL SKILLS HISTORY

HAS YOUR CHILD BEEN TESTED FOR OR DIAGNOSED WITH ANY OF THE FOLLOWING?

	CHECK	COMMENTS
HIGH FUNCTIONING AUTISM (HFA)	☐	
PERVASIVE DEVELOPMENTAL DISORDER (PDD)	☐	
ASPERGER SYNDROME	☐	
NONVERBAL LEARNING DISORDER (NLD)	☐	
ATTENTION DEFICIT DISORDER - HYPER (ADHD)	☐	
ATTENTION DEFICIT DISORDER (ADD)	☐	
EXPRESSIVE/RECEPTIVE LANGUAGE DELAY	☐	
ANXIETY	☐	
DEPRESSION	☐	
BIPOLAR DISORDER	☐	
OPPOSITIONAL DEFIANT DISORDER	☐	
DOWNS SYNDROME	☐	
NO DIAGNOSIS	☐	
OTHER	☐	

WHICH BEHAVIORS DESCRIBE YOUR CHILD? CHECK ALL THAT APPLY.

BEHAVIOR	YES	NO	COMMENTS
MOTIVATED	☐	☐	
IMPULSIVE OPPOSITIONAL	☐	☐	
RIGID	☐	☐	
VERBALLY AGGRESSIVE	☐	☐	
WITHDRAWN	☐	☐	
ANXIOUS	☐	☐	
ALOOF OR INTERNALLY DISTRACTED	☐	☐	
EXTERNALLY DISTRACTED	☐	☐	
TROUBLE WITH TRANSITIONS	☐	☐	
TROUBLE WHEN ROUTINE IS CHANGED	☐	☐	
EASILY FRUSTRATED	☐	☐	
OTHER	☐	☐	