attachment and bonding center of ohio

gregory c. keck phd

# Child Registration Form

PLEASE PRINT

Name of Child______________________________ Birthdate____________________

Parent's name

(Father)______________________________ DOB____________________

(Mother)______________________________ DOB____________________

Address______________________________

______________________________________

Telephone

(Daytime)______________________________ (Evening)____________________

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________________________________________________

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. ______________________________

______________________________

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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: ______________________________________________________________

______________________________________________________________

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