



CLIENT REGISTRATION FORM

Last Updated: 15 December 2014

1

Office Use Only:

Date Received:	
----------------	--

Part 1: Personal Information Required for Registration

CHILD INFORMATION

Full Name:

(First)

(Middle)

(Last)

Diagnosis:

Address:

(Number and Street Name)

(City)

(Province)

(Postal Code)

Phone:

(____) _____

DOB:

(DD/MM/YYYY)

PARENT/GUARDIAN ONE INFORMATION

Name:

(First name)

(Surname)

Address:

(Number and Street Name)

(City)

(Province)

(Postal Code)

Phone:

(H) (____) _____

(W)

(____) _____

(C) (____) _____

Email:

PARENT/GUARDIAN TWO INFORMATION

Name:

(First name)

(Surname)

Address:

(Number and Street Name)

(City)

(Province)

(Postal Code)

Phone:

(H) (____) _____

(W)

(____) _____

(C) (____) _____

Email:

EMERGENCY CONTACT INFORMATION

Name:

Phone:

(____) _____

Relationship to Child:

Part 1: Personal Information Required for Registration (continued)

Alternative Pick Up:
(photo ID required for file)

Phone:

(H)

(____) _____

(W)

(____) _____

(C)

(____) _____

Parent Marital Status:

Married

Common-law

Separated

Divorced

Legal Custody of Child:

Joint

Father

Mother

Parent Relationship to Child:

Biological

Adoptive

Foster

Other

Child's Primary Language

Other Languages in Home:

Others in Household:

Comments:

Part 2: Child's Developmental Milestones

1. How old was your child when he/she first crawled?

2. How old was your child when he/she first walked?

3. How old was your child when first words were spoken?

4. How old was your child when he/she spoke in sentences?

5. Has your child received previous behavioural therapy? Yes No Currently? Yes No
If yes, please provide details including name(s) of therapist(s), frequency, and duration of sessions:

6. Has your child received speech therapy? Yes No Currently? Yes No
If yes, please provide details including name(s) of therapist(s), frequency, and duration of sessions:

7. Has your child received other forms of therapy (e.g. physiotherapy, occupational, play therapy, etc.)?
 Yes No

If yes, please provide details including name(s) of therapist(s), frequency, and duration of sessions:

Note: If possible, please provide all copies of assessments done for diagnosis, and also any psychological, speech, or occupational therapy reports. These reports are very important to the team for programming.

Part 3: Child's Medical Information

Please include a copy of your child's Health Card, Immunization Record, and Birth certificate.

1. Does your child have specific diagnoses or conditions? (e.g. Autism, Seizure Disorder, Apraxia, Ataxia, Dysgraphia, etc.)?

Please name or explain (please clarify if you are waiting for a diagnosis and from whom):

2. Has your child had any significant medical intervention? Yes No

If Yes, please explain:

3. Has your child ever been seriously ill (e.g. high fevers, pneumonia, etc.)? Yes No

If Yes, please explain:

4. Has your child ever been involved in a serious accident (involving head injuries, etc.)? Yes No

If Yes, please explain:

5. Does your child experience frequent nosebleeds? Yes No

Does your child have any blood related diseases? Yes No

If yes to either of the above questions, please explain in further detail (you must also provide us with the blood test results, demonstrating an absence of HIV, Hepatitis, etc.):

5. Is your child currently taking medication(s)? Yes No If Yes, please explain:

Who administers the medication?

Please note: If you wish for TIPES staff to administer medication to your child while at the center, written permission must be obtained from child's parents and physician. Drugs/medication must be provided in the original package.

6. Eye Sight:

Date of the child's last eye exam: _____ Does your child wear glasses? Yes No
If yes, when are glasses required?

Has your child been diagnosed with any visual-related disorders (e.g. Cortical Visual Impairment, etc.)? Yes No
If yes, please explain in further detail:

7. Hearing:

Date of your child's last hearing test: _____
Previous or recurrent middle ear infections: Yes No History of P-E tubes: Yes No
Middle ear functions within normal limits: Yes No Hearing sensitivity within normal limits Yes No
Does your child have a "better" ear? Right Left Same Unknown
Does your child wear hearing aids? Yes No

8. Is there anything else we should know about regarding your child's hearing or eyesight?

9. Preferred hand: Right Left Uses both hands equally

10. Allergies:

Food: _____

Environmental: _____

Other: _____

Part 4: Child's Social and Emotional Life

1. Does your child show an interest in peers? Yes No

2. Does your child interact with peers? Yes No

3. Does your child typically follow familiar instructions without resistance? Yes No

4. Does your child demonstrate any of the following inappropriate behaviours?

Physical aggression towards others Yes No

Self injurious behaviour Yes No

Screaming Yes No

Excessive crying Yes No

Throwing items and/or other destructive actions Yes No

If yes to any of the above, please provide details:

5. Has your child ever been expelled or suspended from school? Yes No

If yes, please explain:

6. What are your child's primary dislikes?

7. What are your child's interests, hobbies, and enjoyed activities?

8. Behaviours (please outline any unique behaviours your child exhibits):

9. Has your child had any educational and/or psychological testing before this time (please provide):

Part 5: Child's Educational Information

Child's School/Preschool Enrolment:

(Name of school)

School's Address:

(Number and Street Name) (City) (Postal Code)

School's Phone Number:

(_____) _____

Board of Education (if applicable):

Educational Support (Please advise the percentage of support your child has been receiving in the classroom (e.g. 50%, 100%, etc.):

If preschool, is support provided through an agency?

Yes

No

If yes, which one?:

Part 6: Parent/Guardian Acknowledgement

Parent/Guardian One:

I acknowledge that the above information is true and accurate:

(Signature)

(Date)

Parent/Guardian Two:

I acknowledge that the above information is true and accurate:

(Signature)

(Date)