ADMISSIONS PACKET

Welcome to WE Play Atlanta.

We would like to start off by thanking you for taking the time to fill out our admission papers. We know this is a lengthy and tedious process however it provides us with valuable information as we learn more about your child.

Please feel free, as always, to contact us by phone or email with any questions you may have.

Sincerely,
The WE Play Team

CLIENT GENERAL INFORMATION

Name: _____ Sex: M F NonBinary

Date of Birth: _____ Phone Number: _____

Address (#1): _____

Address (#2): _____

City: _____ State: _____ Zip Code: _____

School:_____

Grade in School: _____

Teacher/s Name: _____

Referring Physician: _____

Diagnosis: _____

How did you hear about us? _____

Emergency Contact (name & number): _____
(Person you give permission to leave a message with in case of an accident or a therapist emergency)

PARENT/LEGAL GUARDIAN INFORMATION

	Parent	**Parent**
Name:	_____	_____
Address:	_____	_____
Address (line 2):	_____	_____
Cell Number:	_____	_____
Work Number:	_____	_____
Email:	_____	_____
Age at birth of Child:	_____	_____
Overall Health:	_____	_____
Marital Status:	_____	_____
Education:	_____	_____
Occupation:	_____	_____

Other individuals living in the home consistently:

Name	Age	Relationship to the Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MONTHLY STATEMENT INFORMATION

Monthly Statements will be emailed by the 5th of every month for the month prior.

Where would you like your statements emailed to:

Contact Name: _____

Email Address: _____

If you would like statements emailed to a second contact please fill out below:

Contact Name: _____

Email Address: _____

SERVICE PROVIDERS

CURRENT INTERVENTIONS	FREQUENCY/PROVIDER
Occupational Therapy	
Speech Therapy	
Physical Therapy	
Applied Behavior Analysis (ABA)	
DIR (Floortime)	
Counseling/Therapy	
Others _____	

PAST INTERVENTIONS	FREQUENCY/PROVIDER
Occupational Therapy	
Speech Therapy	
Physical Therapy	
Applied Behavior Analysis (ABA)	
DIR (Floortime)	
Counseling/Therapy	
Others _____	

PREGNANCY/BIRTHING HISTORY

This child is:
- A natural child
- An adopted child with no previous medical history available
- An adopted child with medical history available

This child was the product of the ____ pregnancy.
The mother miscarried _____ times prior to this pregnancy.
There was _____ stillbirth prior to this pregnancy.
This child has _____ siblings older than him/her.

Complications experienced by the mother while pregnant with this child included:

_____

_____

_____

Length of Pregnancy: _____ Weight at Birth: _____ Length: _____

Please specify the conditions of your child's birth (check all that apply):
Vaginal Forceps Vacuum C-Section Premature Post mature Full-term

Labor had to be induced because of:

_____

Complications during labor included:

_____

Any indications of difficulties at birth? Please explain:

_____

Child was in intensive care because of:

_____

Child was in intensive care for _____ days.

Length of stay in hospital: _____

While the mother was pregnant, the parents:

	PARENT #1	PARENT #2
RELATIONSHIP TO CHILD		
SMOKED REGULARLY		
SMOKED OCCASIONALLY		
HAD 2 OR MORE DRINKS DAILY		
USED ILLEGAL DRUGS REGULARLY		

On mothers side please list ALL Mental, Physical AND/OR Autoimmune Challenges:

_____

_____

_____

On fathers side please list ALL Mental, Physical AND/OR Autoimmune Challenges:

_____

_____

_____

DEVELOPMENTAL HISTORY

When were your child's difficulties first noted? _____

Who was the first person to notice these difficulties?

_____

Please describe those difficulties?

_____

_____

_____

_____

Complications during development included:

Seizures High fever Feeding difficulties Sleep disturbances Allergies
Serious illness Chronic ear infection Genetic disorder Constipation
Other: _____

If yes to any of the above, please describe:

_____

_____

_____

_____

At what age did your child complete the following developmental milestones:

Roll over: _____ Reach for objects: _____ Sit alone: _____

Belly crawling: _____ Crawling: _____ Cruising: _____

Walk alone: _____ Talking: _____ First Words: _____

Finger feed: _____ Fed self with spoon: _____

Scribble: _____ Toilet train: _____

Hopping: _____ Jumping: _____

Skipping: _____ Running: _____ Riding a tricycle: _____

Riding a bicycle: _____ Jump Rope: _____

HOSPITALIZATIONS/ILLNESSES

Illness	Date	Length of Stay
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS, VITAMINS AND/OR SUPPLEMENTS

Medication	Reason for it	Prescribed by
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER QUESTIONS

Has your child been and/or currently exposed to molds/toxins?_____
If yes, please describe:

_____

_____

Post a viral and/or bacterial infection (ex. Strep, Covid, Flu, etc.) do you notice a change in your child's behaviors? _____
If yes, please describe:

_____

_____

_____

_____

Does your child drink sufficient water during their day? _____

Is your child Potty Trained during the day? _____
Is your child Potty Trained during the night? _____
Please describe:

_____

_____

_____

What time does your child stop drinking liquids for the day? _____

Would you describe your child as a carb, sugar, and or dairy craver?

Does your child eat mostly processed foods or whole foods? _____
Please describe more specific examples of foods here:

_____

_____

_____

Does your child get hangry? _____
If yes, please describe:

_____

_____

_____

Does your child get constipated? _____
Please describe your child's stools (Hard Stool/Constipation/Diarrhea) AND frequency:

_____

_____

_____

How are things going socially at school? Is your child happy? Do they play with peers? Do they have friends?
Please describe:

_____

_____

_____

_____

_____

Have you observed your child socializing in/out of school? Any concerns by parents or teachers?

_____

_____

_____

How does your child regulate their emotions? Do they go from 0-100 without notice? Is it hard for them to "come back" from getting frustrated/upset or they regroup fairly easily?

_____

_____

_____

How much time does your child spend on electronics? _____

What type/s of devices is your child exposed to? _____

Would you describe your child as “addicted” to electronics? If you say it’s time to move on to next activity do they melt down or are they are ok?

_____

_____

_____

What types of activities does your child love to do? Hobbies, After school activities, Etc.

_____

_____

_____

Does your child have difficulty with sleeping? _____
If yes, please describe:

_____

_____

_____

What is/are the hardest time(s) of day? _____
Please describe:

_____

_____

_____

Describe the impact of your child’s challenges with other family members.

_____

_____

_____

_____

_____

What types of activities do you/your spouse enjoy doing with your child?

_____

_____

_____

Describe a typical day with your child.

_____

_____

_____

Please describe your child's strengths:

_____

_____

_____

Please describe your child's difficulties:

_____

_____

_____

GOALS/CONCERNS

What goals do you have for your child (please list ALL even if unsure if related to Occupational Therapy?

_____

_____

_____

_____

_____

_____

What concerns has your child's teacher observed, if any:

_____

_____

_____

_____

_____

_____

Is there anything you would like to share that has not been asked/covered in this questionnaire?

_____

_____

_____

_____

_____

_____

AGAIN, THANK YOU! WE KNOW THIS TAKES TIME TO FILL OUT.

WE LOOK FORWARD TO MEETING YOU AND YOUR CHILD!

SINCERELY,

FLORIE GLUSMAN, OTR/L, OWNER