Brain Works
Live. Love. Learn.

New Client Registration for Children

Date: ___/___/_____

Child's Name: _____

Parent's Name: _____

e-mail address: _____

Contact #: (_____)_____-_____ Can receive texts? _____yes _____no

Street Address: _____

City, State, Zip Code: _____

What is the primary reason for bringing your child to BrainWorks?

What concerns do you have for your child?

What are the expected outcomes?

Child's Date of Birth: ___/___/_____ Birth Weight: _____

_____Natural Delivery _____Caesaren Delivery _____Complications

If a Caesaren Delivery, reason for c-section:

If there were complications, please explain thoroughly:

Was the child in NICU? _____yes _____no

If yes, please explain the reason, the duration, and the outcome:

Developmental Milestones

Did your child meet his/her milestones within the normal time limits?
_____yes _____no

Crawled for several months? _____yes _____no

Crawled in a normal pattern (both knees on the ground, used all four limbs, had coordinated movement)? _____yes _____no

Walked before 10 months? _____yes _____no

Walked after 18 months? _____yes _____no

At what age did your child start talking? _____

Any history of speech difficulties? _____yes _____no

If yes, please explain thoroughly:

Previous Therapies/Interventions

Did your child qualify for early childhood intervention services? _____yes _____no

Has your child ever worked with a speech pathologist? _____yes _____no

Has your child ever worked with an occupational therapist? _____yes _____no

Has your child ever worked with a physical therapist? _____yes _____no

Any diagnosed medical conditions? _____yes _____no

If the answer to any of the above was yes, please explain:

Has your child been diagnosed with a learning disability? _____yes _____no

If yes, please explain:

Is your child on a 504 or IEP? _____yes _____no

If yes, please explain:

Has your child received counseling services? _____yes _____no
If yes, please explain:

Has your child received any academic interventions outside of the school setting?
_____yes _____no

If yes, please explain:

Other important information you would like to share:

Behavior and Symptom Checklist

Please rate each behavior or symptom for your child.
0= not at all, never. 5= regularly, nearly constant or persistent

Behavior/Symptom	0	1	2	3	4	5
Academic and Organizational Skills						
Difficulty reading						
Difficulty with mathematics						
Difficulty with writing						
Poor handwriting						
Difficulty Spelling						
Slow, methodical worker						
Difficulty Sequencing						
Perfectionist about work						
Attention/Focus/Executive Function						
Trouble getting and staying organized						
Difficulty getting started on work						
Difficulty sustaining attention on non-preferred tasks						
Needs constant redirection						
Difficulty completing assignments						
Easily distracted						
Seems to fatigue with work quickly						
Sensory Processing						
Sits in odd positions when reading						
Rubs eyes						
Sensitive to bright lights						
Poor hand-eye coordination						

Behavior/Symptom	0	1	2	3	4	5
Skips words with reading						
Overwhelmed by sounds						
Startles with loud sounds						
Frequently “tunes out”						
Difficulty following verbal instructions						
Ringing in ears						
Difficulty working in noisy room						
Easily distracted by noise						
Doesn’t remember teacher/parent directions						
Gets carsick						
Sensitive to textures like clothing or food						
Physical Skills						
Uncoordinated/Clumsy						
Avoids physical activity like running or bike riding						
Difficulty sitting still						
Lacks balance						
Low muscle tone						
Rigid body and/or movements						
Difficulty with fine motor skills						
Always moves quickly						
Walks on toes						

Behavior/Symptom	0	1	2	3	4	5
Doesn't know left and right						
Holds head up when writing or reading						
Sits with feet under torso						
Difficulty swimming						
Difficulty throwing and catching						
Often leans against things when standing						
Social-Emotional-Behavioral Skills						
Easily overexcited						
Easily overwhelmed						
Resistant to changes in routine or physical environment						
Obsessive or perseverative thoughts						
Difficulty with self-regulation						
Difficulty with transitions						
Lack of physical self-awareness						
Anxious						
Social anxiety/shyness						
Needs to control others or routine						
Suffers from panic attacks						
Poor self-image						
Impulsive						
Unable to take responsibility for actions						
Makes things up to shift blame away from self						
Aggressive with others when upset						

Behavior/Symptom	0	1	2	3	4	5
Health Concerns						
Food sensitivities/allergies						
Environmental allergies						
Chemical sensitives						
Exhibits physical tics						
Asthma						
Eczema, psoriasis						
Chronic cold symptoms						
Swallowing or eating difficulties						
Fatigue						
Frequent headaches or migraines						
Picky eater						
Craves Sweets						
Difficulty falling asleep						
Difficulty staying asleep						
Feelings tired even after a full night's sleep						
Slow to wake up in the morning						
Bedwetting (past or present)						
Self-Expression						
Difficulty expressing ideas orally						
Difficulty expressing ideas in writing						
Stutters						

Non-verbal						
Talks constantly						
Is unaware of voice volume						
Mouth moves with hand movement						
Speech articulation difficulties						
Slow to respond to questions						
Frequently interrupts speaker						