CONFIDENTIAL INFORMATION

Child Registration

DATE____________________ Melbourne Clinic ☐ Main Beach Clinic ☐

Child's Details

Name ____ Male / Female

Date of Birth________________ Residence ☐ Parents ☐ Mother ☐ Father

Mother Name ____

Date of Birth________________ Occupation ____________________________

Address ____

Suburb________________________________State__________ Postcode________

Telephone ___________________________Mobile ___________________________

Email ____

Father Name ____

Date of Birth________________ Occupation ____________________________

Address ____

Suburb________________________________State__________ Postcode________

Telephone ___________________________Mobile ___________________________

Email ____

Method of Payment

☐ Cash ☐ EFTPOS ☐ Work Cover ☐ DVA ☐ TAC ☐ FaHCSIA

☐ Other ☐ EAP Company Name ______________________________

I accept to be charged 50% of my consultation fee when a MINIMUM of 24 HOURS NOTICE is not given for cancelling or postponing an appointment

Client Signature_________________________________DATE________________

Psychologist Signature____________________________DATE________________

Contact List

School/Childcare____

Phone No____________________ Teacher/ Room Leader______________________

Speech Therapist_________________________________Phone________________

Occupational Therapist____________________________ Phone ________________

Doctor ____ Phone________________

Specialist____ Phone________________

Family Dynamics

Father's Family History *Anxiety* *Depression* *Other*________________

Father's parenting *Easy going* *rigid discipline* *fair and firm* *indulgent*

(Circle answers)

Mother's Family History *Anxiety* *Depression* *Other*_______________

Mother's parenting *Easy going* *rigid discipline* *fair and firm* *indulgent*

Discipline Mother mostly Father mostly Equally shared *(circle)*

Type of Discipline administered

____

____

Siblings

Name	Age	R/ship - child (*Good Normal Poor)*

Pets ____

Pets relationship with Child____

Other Significant People / Things in your child's life_____________________________

____

____

____

____

Prenatal History

Problems during Pregnancy, Labour,

Delivery____

Note any problems with

crying __________________________vomiting_____________________________

feeding _________________________ colic _______________________________

diarrhoea________________________sleeping_____________________________

Other____

Medical, Physical & Development History

Hearing tested Y / N ___________________ Sight tested Y / N _____________

Began to talk in sentences at __________ age Walked at ______________ months

Sensitive to noise Y/N ________________ Sensitive to lots of activity Y/N________

Sensitive to the feel of fabrics Y/N _____________ Sensitive to being touched Y/N

Dislikes change to usual routine or the way things are done Y/N ________________

___________________ Sensitive to being watched by others Y/N _______________

Can play alone for a short periods Y/N ____________________________________

Sometimes the child allows the parent to be in charge of play (building lego, pretend play) Y / N ____

Fine motor problems (writing, holding a knife and fork) Y / N _________________

Gross motor (hopping, running) Y/N ______________________________________

Experienced any trauma or loss Y/N ______________________________________

Ever Hospitalised Y / N __________________________Number of times _____

Medical condition ____

____

Any medical trauma (medical tests / procedures requiring physical restraint) Y / N

If yes, At age / s_______________ Procedure/ s __________________________

____

Other developmental/behavioural/ medical concerns

____

____

____

Presenting Behavioural Profile
circle L (low) N (normal) H (high) Y (yes) N (no)

Comments

Sleeping quality L N H ______________________________

Appetite L N H ______________________________

Self esteem L N H ______________________________

Pretend Play Y / N______________________________

Tantrums Y / N ______________________________

Sadness Y / N ______________________________

Caring, thoughtful Y / N ______________________________

Makes friends Y / N ______________________________

Fear of .... Y / N ______________________________

Stealing, Lying Y / N ______________________________

Outgoing, social Y / N______________________________

Shy Y / N ______________________________

Low energy Y / N ______________________________

Physical Aggression Y / N ______________________________

Separation anxiety Y / N ______________________________

Nightmares / Night Terrors Y / N ______________________________

Bed wetting Y / N______________________________

Concentration problems Y / N______________________________

Toilet trained Y / N ______________________________

Restlessness Y / N ______________________________

Cruelty to children , animals Y / N ______________________________

Stomach aches, headaches Y / N ______________________________

Destruction of property Y / N ______________________________

Need to be Perfect Y / N ______________________________

Lack of fun Y / N ______________________________

Worried, scared Y / N ______________________________

Concerned with fairness Y / N ______________________________

Stubborn / Oppositional Y /N ______________________________

Lines up toys or objects Y / N ______________________________

Manipulating Behaviour Y/N ______________________________

Other concerns

____

____

Kinder / Preschool / Prep / School Performance (*circle)*

Academic	low	normal range	high
Behaviour	low	normal range	high
Social	low	normal range	high

Day to Day Overview of Child

Child's favourite Activity____

Child's favourite Game____

Child's favourite TV/Film/Book character___________________________________

Does your child take part in any after school or week end activities Y / N

____

Amount of time child spends at the computer and TV on a week day_____________

How my child copes with problems

____

Things my child loves

____

My child's greatest strengths are____

____

My child's greatest challenges are____

____

Goals of Therapy in order of priority

1. ____
2. ____
3. ____
4. ____