



Lighthouse Project

*Providing Occupational and Speech Therapy Services for Children with Unique Learning Needs
Specializing in the Treatment of Asperger's, NLD and HFA*

New Client Registration Information

Date: _____ Client's (child) Name: _____ D.O.B. _____

Parent/ Guardian Name: _____

Home Address: _____

Home Phone: _____ Email: _____

Mom's Cell#: _____ Dad's Cell#: _____

Work Phone(s): _____ Fax#: _____

Client's School Name, Grade 7 District: _____

Best Contact at School (Name and Phone): _____

Is he/she is enrolled in a Special Education class or any specific service? If so, please list:

What are your main concerns about your child's performance at school?

What are your main concerns about your child's performance at home?



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Please state the special interests your child has at school and home:

Please list the activities or topics your child struggles with the most at school and home:

RATE YOUR CHILD'S BEHAVIOR ON A SCALE FROM 1-10 (1- LOWEST, 10- HIGHEST)

BEHAVIOR	HOME	SCHOOL
Paying attention to others		
Listening		
Participating in conversations		
Being organized		
Personal problem solving		
Understanding feelings of others		
Assuming responsibility		
Processing information in a timely manner		
Activities of daily living (ADL- washing, dressing, etc.)		
Showing affection		
Volatility / impulsivity		
Understanding consequences		
Working in groups		
Other:		

If you have any copies of diagnostic reports (private or school-based), last year's IEP, and/or any other reports; it would be helpful to bring a copy.




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The clinic director will need a **CONSENT TO SHARE INFORMATION** form signed, for each professional you would like her to speak with regarding your child. Please request this form at the time of your parent intake appointment.

Please provide your signature and the date to officially start your registration process and treatment scheduling.
Thank you!

Signature:  _____ Date: _____