Group Therapy Application
(7 & under)

For admin use only:	For admin use only:

TODAY'S DATE: ____________________

CLIENT INFORMATION

Name (first/last): ___________________________ Gender: ☐ M ☐ F DOB (mm/dd/yy): ______________

Referred By: ____ Age (yrs/mo): _________________

Services requesting or referred for:

☐ Social Group Therapy ☐ Individual Social Therapy ☐ Occupational Therapy ☐ Speech Therapy
☐ Evaluation ☐ Screening ☐ Consultation

*****Requested/recommended service may change based on child's most immediate needs*****

Describe any general concerns you have regarding your child: ____________________________________

____
____
____

PARENT/GUARDIAN INFORMATION

Primary Contact (first/last): ____________________________________ Relation to Client: __________________

Address:____

☐ Home: _______________ ☐ Cell: ____________ ☐ Work: _____________ ☐ Email: __________________

Second Contact (first/last): ___________________________________ Relation to Client: ___________________

☐ Home: _______________ ☐ Cell: _____________ ☐ Work: _____________ ☐ Email: __________________

List other caregivers that are permitted to participate in drop off, pick up, and wrap-ups:

Name: ____________________________________ Phone: _________________ Relation: ________________

Name: ____________________________________ Phone: _________________ Relation: ________________

BILLING INFORMATION *required*

PARENTS/CAREGIVERS

*Email: ____ **all invoices are sent by email*

Address: ____________________________________City: ___________________ State: ______ Zip: ________

INSURANCE INFORMATION

Insurance Company Name/Ph Num:______________________________ Member ID#:_______________

Insured's Name and Date of Birth:____

REGIONAL CENTER CLIENTS *If you are not a Regional Center client skip to SCHEDULE AVAILABILITY section*

Have you spoken with your Case Manager about Services? ☐ Yes ☐ Not Yet

Case Manager (first/last): ____ Phone: ___________________

SCHEDULE AVAILABILITY

List the blocks of time you are **available** to participate in therapy for each day of the week. Write *NA* on days that will not work for you.

Keep in mind that group placement involves juggling multiple schedules, ages, and needs. This is a critical part of our process in providing effective treatment. The more availability you provide the easier it will be for us to group your child.

Hours of Operation		Your availability
8am to 7pm	Monday	
	Tuesday	
	Wednesday	
	Thursday	
	Friday	
8am to 4pm	Saturday	

BIRTH HISTORY

Birth Weight: _______lbs. _______ oz. Number of days' baby was in hospital after delivery: _______

Were there complications during (check all that apply):

☐ Pregnancy ☐ Delivery ☐ Post-Delivery OR ☐ Normal/ No Complications

If complications, briefly describe (e.g. weak suck nursing, vomiting, diarrhea, infections, low muscle tone):

____

FAMILY HISTORY/ENVIRONMENT

List language(s) spoken at home: ____

Child is: ☐ Biological ☐ Foster ☐ Adopted At what age? __________

Child resides with (check all that apply):

☐ Biological Mother ☐ Foster Mother(s) ☐ Adoptive Mother(s)

☐ Biological Father ☐ Foster Father(s) ☐ Adoptive Father(s) ☐ Other: ________________________

List sibling name(s), ages(s), and if they have medical, social, or academic concerns:

Name	Age	Concerns (if applicable)

List any family members who have medical, physical, speech/language, social, academic, or learning challenges:

Relation to Client	Concern(s)

MEDICAL HISTORY

History of medical concerns (check all that apply):

- ☐ Feeding Problems
- ☐ Eye Problems
- ☐ Head Trauma
- ☐ High Fever
- ☐ Tonsillitis
- ☐ Chronic Colds/Respiratory Infections
- ☐ Allergies
- ☐ Asthma
- ☐ Chronic Ear Infections
- ☐ Hearing Impairment
- ☐ Temporary Hearing Loss
- ☐ Other: ______________________________

Diagnoses (e.g., autism, social anxiety, attachment disorder, attention deficit disorder, cerebral palsy, sensory processing disorder):

____

Pediatrician: ______________________________ last seen: ______________

Hearing test: ☐ Yes ☐ No If yes, when? __________________ results: __________________

Vision test: ☐ Yes ☐ No If yes, when? __________________ results: __________________

List current medications: ______________________________

List past medications: ______________________________

List food allergies: ______________________________

List special diet/dietary restrictions: ______________________________

EDUCATION *If your child is not currently in school skip to CURRENT SERVICES section*

Current School/day care: ______________________________

Type: ☐ Preschool ☐ Special Day Class ☐ Regular Ed ☐ Other __________ ☐ Aide ___% of school day

How is your child doing academically? ☐ Excellent ☐ Satisfactory ☐ Poor

List any concerns your child's teacher has expressed to you: ______________________________

____

____

I give consent for Seven Bridges Therapy staff to speak with my child's current teacher. ☐ Yes ☐ No

Teacher (first/last): ______________________________ Phone: ______________________

CURRENT & PAST SERVICES *If your child has never received therapy services skip to DEVELOPMENT section*

Please list all past and/or current therapy services your child has received.

Therapy Type & Location	Therapist (first/last)	Session Frequency	Last seen

Current Therapy Goals: ______________________________

____

DEVELOPMENT

I've noticed my child has/is (check all that apply):

- ☐ Not cooing or babbling
- ☐ Frequent hospitalization
- ☐ Resistant to cuddling
- ☐ Difficult to calm
- ☐ Colicky
- ☐ Separation anxiety from a parent
- ☐ Avoiding eye contact
- ☐ Nonresponsive when spoken to
- ☐ Unusual play methods
- ☐ Not gesturing (e.g., waving bye bye)
- ☐ Not pointing or requesting
- ☐ Restless
- ☐ Inactive
- ☐ Difficulty sharing
- ☐ Difficulty sleeping
- ☐ Difficulty eating

Did your child reach the following milestone at the typical age?

Milestones	**Age in months**	**Yes**	**No**	**If No, then at what age?**
Pointed	6 – 9	☐	☐	________
Smiled	3 – 6	☐	☐	________
Sat without support	6 – 8	☐	☐	________
Crawled	8 – 13	☐	☐	________
Walked with assistance	12 – 15	☐	☐	________
Spoke first words	12	☐	☐	________
Spoke in 2 - 3 word sentences	18	☐	☐	________
Eating with fingers	7 – 9	☐	☐	________
Using cup/spoon	18 – 24	☐	☐	________
Sipped from open cup	24 – 36	☐	☐	________
Potty trained during day	24 – 36	☐	☐	________
Dressed self & fasteners	42 – 48	☐	☐	________
Bathed self	72 - 78	☐	☐	________
Brushed teeth	72 - 78	☐	☐	________

Does your child (check all that apply):

☐ Repeat sounds, words, or phrases over and over
☐ Retrieve/point to common objects when requested
☐ Follow simple directions
☐ Respond correctly to who/what/when questions
☐ Understand what you are saying
☐ Respond correctly to yes/no questions

How does your child currently communicate?

☐ Body Language
☐ Sounds (vowels, gurgling)
☐ Words (shoe, doggy)
☐ 2 - 4 word sentences
☐ Sentences longer than 4 words

☐ Other: ______________________________

At what age did you first become concerned about your child's physical, speech, language, and/or communication skills and why?

____

SOCIAL LEARNING INFORMATION

The following questions will help us get to know your child and aid with appropriate group placement. Your accuracy and honesty will help us understand each child and their needs.

Use the following scale to rate your level of concern regarding your child's ability to:

0 = not concerned, 1 = some concern, 2 = concerned, 3 = very concerned

_____ Socialize with other children
_____ Express thoughts and ideas
_____ Pronounce words and sounds
_____ Understand and follow directions
_____ Pay attention and focus (e.g., thinking about what the group is thinking about)
_____ Regulate emotions and feelings
_____ Manage his/her body (e.g., sensory processing/personal space, seeking out roughhousing, difficulty sitting still)
_____ Use age appropriate gross motor skills (e.g., running, jumping, etc.)
_____ Use age appropriate fine motor skills (e.g., handwriting, etc.)

Check the box if you would describe your child's temperament/characteristics as the following:

☐ Quiet, calm, relaxed, patient
☐ Active, outgoing, enthusiastic
☐ Worried, anxious, nervous, habits/tics
☐ Sad, fatigued, tired, low energy
☐ Internally distracted (e.g., preoccupied with own thoughts)
☐ May yell or hit when upset
☐ Externally distracted (e.g., preoccupied with environmental distractions)
☐ Passive, quiet, withdrawn (may hide or emotionally shut down when upset)
☐ Intense, demanding
☐ Hyperactive, always in motion
☐ Impulsive
☐ Rigid, inflexible, becomes easily frustrated
☐ Picky eater
☐ Irregular sleep patterns

Other (please describe): ______________________________

List triggers related to behavioral challenges: ______________________________

Using the following scale, rate how your child plays:

Skill Area	Never	Rarely	Some-times	Often	Always	Comments
Is primarily focused on objects rather than people	☐	☐	☐	☐	☐	
Appropriately makes eye contact with others	☐	☐	☐	☐	☐	
Is focused primarily on their own play rather than their peers	☐	☐	☐	☐	☐	
Pretends objects are other things (e.g., a pencil is a toothbrush)	☐	☐	☐	☐	☐	
Uses 3 - 4 steps in sequence when acting out play routines (e.g., mix cake, bake it, eat it)	☐	☐	☐	☐	☐	
Notices and watches peers playing	☐	☐	☐	☐	☐	
Plays next to peers (in parallel)	☐	☐	☐	☐	☐	
Initiates interactions with peers (e.g., hands them a toy, asks a question)	☐	☐	☐	☐	☐	
Shares ideas with peers via conversation or play	☐	☐	☐	☐	☐	
Wants to lead the play (e.g., refuses others ideas, dictates play sequence)	☐	☐	☐	☐	☐	
Follows others interests AND ideas in play (e.g., adding a fireman to house play)	☐	☐	☐	☐	☐	
Pays attention to adults/follows an adult's lead	☐	☐	☐	☐	☐	
Focuses on peers in play rather than adults	☐	☐	☐	☐	☐	
Plays on his/her own with a peer for 5 - 10 minutes without adult facilitation	☐	☐	☐	☐	☐	
Takes 3 - 4 turns with peers	☐	☐	☐	☐	☐	
Independently problem solves in play (e.g., fixing a broken car, taking the boy to the doctor)	☐	☐	☐	☐	☐	
Has difficulty transitioning to a new activity	☐	☐	☐	☐	☐	
Shows empathy for others	☐	☐	☐	☐	☐	