



# Carruth Center, Inc

11001 Hammerly Blvd. Houston Texas 77043 713-935-9088 713-935-0654 (fax)

## Case History

Date: \_\_\_\_\_

Information provided by: \_\_\_\_\_

**Child's Name:** \_\_\_\_\_

First

Middle

Last

Name Called

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Who has legal custody of this child? \_\_\_\_\_

Is this child adopted? \_\_\_\_\_ At what age? \_\_\_\_\_ Is he/she aware of this? \_\_\_\_\_

**Father:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(if different)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Contact Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell#: \_\_\_\_\_

Email Address: \_\_\_\_\_

Marital Status: \_\_\_\_\_  
married to child's mother (biological or adoptive), single, separated, divorced, widowed, remarried

Occupation: \_\_\_\_\_ Place of Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_

Education/Highest Degree: \_\_\_\_\_

**Mother:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(if different)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Contact Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell#: \_\_\_\_\_

Email Address: \_\_\_\_\_

Marital Status: \_\_\_\_\_  
married to child's father (biological or adoptive), single, divorced, widowed, remarried

Occupation: \_\_\_\_\_ Place of Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_

Education/Highest Degree: \_\_\_\_\_

**Confidential and Privileged**

Please list the occupants of your child's:

Household 1: \_\_\_\_\_

Household 2: \_\_\_\_\_

Name                      Age      Relationship to child

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name                      Age      Relationship to child

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is any language other than English spoken in the home? \_\_\_\_\_ Which? \_\_\_\_\_

Who referred you to The Carruth Center? \_\_\_\_\_

**FAMILY HEALTH HISTORY, MENTAL ILLNESS, AND/OR DEVELOPMENTAL PROBLEMS:**

Please check Yes or No for each of the medical conditions below which apply to a family member, then list relation to the right (e.g., mother, brother, paternal grandfather, maternal uncle, etc.)

- |                          |                          |  |
|--------------------------|--------------------------|--|
| Yes                      | No                       |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid _____                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease _____                      |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure _____                |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision Problems _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures _____                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Defects _____                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental Retardation/Down's Syndrome _____ |

- |                          |                          |                        |
|--------------------------|--------------------------|------------------------|
| Yes                      | No                       |                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer _____           |
| <input type="checkbox"/> | <input type="checkbox"/> | Sudden Death _____     |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing Problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral Palsy _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis _____        |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes _____         |

Please list any other diseases that run in the family:

\_\_\_\_\_  
\_\_\_\_\_

- |                          |                          |   |
|--------------------------|--------------------------|---|
| Yes                      | No                       |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervous Breakdown _____                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional Problems _____                |
| <input type="checkbox"/> | <input type="checkbox"/> | Delinquency Problems _____              |
| <input type="checkbox"/> | <input type="checkbox"/> | Substance Abuse _____                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Bed Wetting after 5 yr. _____           |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperactivity / ADHD _____              |
| <input type="checkbox"/> | <input type="checkbox"/> | Schizophrenia _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Learning Problems: Please specify _____ |

- |                          |                          |  |
|--------------------------|--------------------------|--|
| Yes                      | No                       |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Bipolar Disorder _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Autism / PDD _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Speech Problems / Delays _____             |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating Problems (anorexia / bulimia) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety _____                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Post-partum Depression _____               |
| <input type="checkbox"/> | <input type="checkbox"/> | Obsessive Compulsive Disorder _____        |
| <input type="checkbox"/> | <input type="checkbox"/> | Phobias _____                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: Please specify _____                |

**CURRENT CONCERNS:**

Please check below if you have any concerns about your child in these areas:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Short Attention Span          | <input type="checkbox"/> Attention seeking | <input type="checkbox"/> Distractibility          |
| <input type="checkbox"/> Impulsivity                   | <input type="checkbox"/> Hyperactivity     | <input type="checkbox"/> Avoidance                |
| <input type="checkbox"/> Low frustration tolerance     | <input type="checkbox"/> Noncompliance     | <input type="checkbox"/> Anxiety                  |
| <input type="checkbox"/> Oppositional behavior         | <input type="checkbox"/> Social Isolation  | <input type="checkbox"/> Low self-esteem          |
| <input type="checkbox"/> Aggression                    | <input type="checkbox"/> Lying             | <input type="checkbox"/> Awareness of differences |
| <input type="checkbox"/> Difficulties with transitions | <input type="checkbox"/> Self-stimming     | <input type="checkbox"/> Difficulties separating  |

Please list any additional concerns about your child: \_\_\_\_\_

When did these problems begin? \_\_\_\_\_

**PRE AND PERI-NATAL HISTORY:**

Was this a planned pregnancy:  Yes  No Fertility? \_\_\_\_\_

**MEDICAL HISTORY DURING PREGNANCY:**

Please answer which of the following conditions may have occurred during this pregnancy and explain in the space below:

<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>	
<input type="checkbox"/>	<input type="checkbox"/>	Edema (swelling of the hands and feet)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy (Seizure)
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Infections (colds, flu, urinary tract, rubella, vaginal)
<input type="checkbox"/>	<input type="checkbox"/>	Toxemia	<input type="checkbox"/>	<input type="checkbox"/>	Other Illnesses
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco/ Alcohol/ Controlled Substance use
<input type="checkbox"/>	<input type="checkbox"/>	X-ray studies			Frequency: _____
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization			Injuries (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Operations (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes

Please explain all *Yes* answers: \_\_\_\_\_

**BIRTH HISTORY:**

Length of Labor: \_\_\_\_\_

- |                           |                                    |   |
|---------------------------|------------------------------------|---|
| Type of Labor Onset:      | <input type="checkbox"/> Induced   | <input type="checkbox"/> Spontaneous                                      |
| Type of Birth:            | <input type="checkbox"/> C/Section | <input type="checkbox"/> Vaginal  |
| Type of Anesthesia:       | <input type="checkbox"/> Gas       | <input type="checkbox"/> Spinal (epidural) <input type="checkbox"/> Local |
| Was the baby on time?     | <input type="checkbox"/> Yes       | <input type="checkbox"/> No   |
| If <u>No</u> , was he/she | <input type="checkbox"/> Early or  | <input type="checkbox"/> Late, and by how many weeks? _____               |

Age of Mother at birth: \_\_\_\_\_

Age of Father at birth: \_\_\_\_\_

Number of Children Born: \_\_\_\_\_

Does either parent have children from previous relationships? If so, please list names & ages below:

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Child's Name \_\_\_\_\_

**Problems during Labor:**

- |                          |                          |                   |                          |                          |                  |
|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|------------------|
| <b>Yes</b>               | <b>No</b>                |                   | <b>Yes</b>               | <b>No</b>                |                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Toxemia/Eclampsia | <input type="checkbox"/> | <input type="checkbox"/> | Fetal Distress   |
| <input type="checkbox"/> | <input type="checkbox"/> | Maternal Fever    | <input type="checkbox"/> | <input type="checkbox"/> | Medications Used |

How much did your child weigh? \_\_\_\_\_

Apgar Scores: \_\_\_\_\_

**Check if any of the following problems occurred after the child's birth and explain in the space below:**

- |                          |                          |                                  |                          |                          |                |
|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|----------------|
| <b>Yes</b>               | <b>No</b>                |                                  | <b>Yes</b>               | <b>No</b>                |                |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble Breathing                | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice       |
| <input type="checkbox"/> | <input type="checkbox"/> | Cord around the Neck             | <input type="checkbox"/> | <input type="checkbox"/> | Poor Feeding   |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever                            | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting       |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhage (Bleeding) in Head    | <input type="checkbox"/> | <input type="checkbox"/> | Floppy         |
| <input type="checkbox"/> | <input type="checkbox"/> | Large Ventricles (Hydrocephalus) | <input type="checkbox"/> | <input type="checkbox"/> | Incubator Care |
| <input type="checkbox"/> | <input type="checkbox"/> | Cyanosis (turned blue)           | <input type="checkbox"/> | <input type="checkbox"/> | Infection      |
| <input type="checkbox"/> | <input type="checkbox"/> | Need for Ventilation/Oxygen      | <input type="checkbox"/> | <input type="checkbox"/> | Other          |

Please explain all Yes answers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How many days after birth was mother discharged from hospital? \_\_\_\_\_

How many days after birth was child discharged from hospital? \_\_\_\_\_

**Previous Obstetrical History:**

How many full-term pregnancies has mother had? \_\_\_\_\_

What were the dates? \_\_\_\_\_

Any abortions, miscarriages, or still births? \_\_\_\_\_

What were the dates? \_\_\_\_\_

**CHILD DEVELOPMENT:**

Was your child breast-fed?      Yes    No

Duration? \_\_\_\_\_

Describe the circumstances around stopping:

Describe the weaning: \_\_\_\_\_

Was your child bottle-fed?      Yes    No

Duration? \_\_\_\_\_

Describe the circumstances around stopping:

Please check any of the following that described your child as an infant:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Fussy               | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Reflux            |
| <input type="checkbox"/> Easy to soothe      | <input type="checkbox"/> Feeding problems  | <input type="checkbox"/> Failure to Thrive |
| <input type="checkbox"/> Difficult to soothe | <input type="checkbox"/> Cried excessively | <input type="checkbox"/> RSV               |
| <input type="checkbox"/> Startled easily     | <input type="checkbox"/> Colic             | <input type="checkbox"/> Other _____       |

What are your child's sleeping arrangements?

Room alone  With sibling  With parents  With others

Does your child sleep in  crib  bed

Does he/she sleep through the night?  Yes  No

If not, how many times does he/she awaken at night? \_\_\_\_\_

For how long? \_\_\_\_\_

What helps him/her get back to sleep? \_\_\_\_\_

Did/Does your child have a special object (blanket, teddy bear, etc.)?  Yes  No

If yes, please describe \_\_\_\_\_

If yes, until what age? \_\_\_\_\_

Does he/she have any self-soothing behavior?  Yes  No

If yes, does he/she  suck fingers/thumb  use pacifier  twirl hair

other, please describe \_\_\_\_\_

Does your child exhibit any behaviors that you consider 'odd' or 'unusual'? \_\_\_\_\_

How many hours of TV and/or video does your child watch each day? \_\_\_\_\_

What are his/her favorites? \_\_\_\_\_

**Developmental Milestones: (age of mastery)**

When did your child do the following (Please list specific age if possible):

	Early?	Late?	On time?	AGE
Smile	_____	_____	_____	_____
Laugh	_____	_____	_____	_____
Maintain eye gaze	_____	_____	_____	_____
Imitation	_____	_____	_____	_____
Gestures (pointing)	_____	_____	_____	_____
Roll over	_____	_____	_____	_____
Sit	_____	_____	_____	_____
Crawl	_____	_____	_____	_____
Stand	_____	_____	_____	_____
Walk	_____	_____	_____	_____
Wave Bye-Bye	_____	_____	_____	_____
Toilet Trained (day)	_____	_____	_____	_____
(night)	_____	_____	_____	_____
Babbling	_____	_____	_____	_____
Cooing	_____	_____	_____	_____
First words	_____	_____	_____	_____

What were your child's first words? \_\_\_\_\_

When did your child put two words together? \_\_\_\_\_

Could you understand your child's speech by age 2?  Yes  No

Could others understand your child's speech by age 2?  Yes  No

Could your child speak in simple sentences by age 2?  Yes  No

How does your child typically communicate?  Gesture  Words  Sentences

Does your child recite scripts from movies or TV?  Yes  No

Please describe any areas of concern (articulation, socialization, receptive language, expressive language, echolalia (parroting what is said)):  
 \_\_\_\_\_  
 \_\_\_\_\_

When did your child:

	Early	Late	On time	AGE
Use writing utensils	_____	_____	_____	_____
Use eating utensils	_____	_____	_____	_____
Run smoothly	_____	_____	_____	_____
Snap	_____	_____	_____	_____
Button	_____	_____	_____	_____
Zip	_____	_____	_____	_____
Jump with 2 feet	_____	_____	_____	_____
Tie Shoes	_____	_____	_____	_____
Climb play equipment	_____	_____	_____	_____
Ride a bike: tricycle	_____	_____	_____	_____
Training wheels	_____	_____	_____	_____
Two-wheeler	_____	_____	_____	_____
Skip with coordination	_____	_____	_____	_____

Please describe any areas of concern (i.e., fine or gross motor, balance) \_\_\_\_\_  
 \_\_\_\_\_

Did your child do any head banging? \_\_\_\_\_ At what age? \_\_\_\_\_

Is he / she left-handed or right-handed? \_\_\_\_\_ Does he / she change from hand to hand? \_\_\_\_\_

**MEDICAL HISTORY:**

Child's Physician: \_\_\_\_\_ Telephone #: \_\_\_\_\_

What major illnesses, hospitalizations, or operations has your child had? Please explain when the incident happened, what occurred, and how your child and each parent experienced this event.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have any concerns about your child's physical health?  Yes  No

If YES, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

When was your child's last physical exam? \_\_\_\_\_ Where? \_\_\_\_\_

**Please check which of the following your child has had and note the age, complications and frequency below:**

<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	measles	<input type="checkbox"/>	<input type="checkbox"/>	mumps
<input type="checkbox"/>	<input type="checkbox"/>	chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	whooping cough	<input type="checkbox"/>	<input type="checkbox"/>	viral infections
<input type="checkbox"/>	<input type="checkbox"/>	trauma (broken bones/stitches)	<input type="checkbox"/>	<input type="checkbox"/>	hospitalizations
<input type="checkbox"/>	<input type="checkbox"/>	concussions (age and treatment)	<input type="checkbox"/>	<input type="checkbox"/>	surgery
<input type="checkbox"/>	<input type="checkbox"/>	hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	asthma
<input type="checkbox"/>	<input type="checkbox"/>	allergies	<input type="checkbox"/>	<input type="checkbox"/>	tremor

Child's Name \_\_\_\_\_

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	meningitis (viral/bacterial)	<input type="checkbox"/>	<input type="checkbox"/>	RSV
<input type="checkbox"/>	<input type="checkbox"/>	persistent high fever	<input type="checkbox"/>	<input type="checkbox"/>	coma
<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	head trauma
<input type="checkbox"/>	<input type="checkbox"/>	loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	pica (eating nonfood items, such as dirt or paper)
<input type="checkbox"/>	<input type="checkbox"/>	staring spells	<input type="checkbox"/>	<input type="checkbox"/>	bed wetting
<input type="checkbox"/>	<input type="checkbox"/>	accidental poisoning	<input type="checkbox"/>	<input type="checkbox"/>	stool soiling
<input type="checkbox"/>	<input type="checkbox"/>	vision problems	<input type="checkbox"/>	<input type="checkbox"/>	bowel problems
<input type="checkbox"/>	<input type="checkbox"/>	floppy	<input type="checkbox"/>	<input type="checkbox"/>	falls frequently
<input type="checkbox"/>	<input type="checkbox"/>	seizures	<input type="checkbox"/>	<input type="checkbox"/>	excessive vomiting
<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	anemia
<input type="checkbox"/>	<input type="checkbox"/>	ear infections (how many?) _____	<input type="checkbox"/>	<input type="checkbox"/>	medication for convulsion
<input type="checkbox"/>	<input type="checkbox"/>	other infections:	<input type="checkbox"/>	<input type="checkbox"/>	medication for hyperactivity
<input type="checkbox"/>	<input type="checkbox"/>	tics	<input type="checkbox"/>	<input type="checkbox"/>	medication for other illnesses (not including colds or ear infections)
<input type="checkbox"/>	<input type="checkbox"/>	other long term medical complaints/problems			

Please explain all **YES** answers, including age and treatment for each. \_\_\_\_\_

---



---



---



---



---



---



---

Please list all medication you child has taken or is currently taking, and the dosage \_\_\_\_\_

---



---



---

Has your child had a neurological examination? If so, where and when? What were the results? \_\_\_\_\_

---



---

Has your child had a psychological examination? If so, where and when? What were the results? \_\_\_\_\_

---



---

**SOCIAL/BEHAVIORAL HISTORY:**

How does your child get along within the family circle? \_\_\_\_\_

\_\_\_\_\_

Does your child play well with siblings? \_\_\_\_\_

Does your child prefer to play alone? \_\_\_\_\_

Does your child prefer to play with  older,  younger or  same age peers? (Please check)

Is your child aware of his/her difficulties? \_\_\_\_\_

What are your child's favorite activities? \_\_\_\_\_

\_\_\_\_\_

What methods of discipline are used?

- Rewards
- Time out
- Avoidance of child
- Other \_\_\_\_\_
- Verbal reprimands
- Removal of privileges
- Physical punishment

What are your child's reactions to discipline? \_\_\_\_\_

\_\_\_\_\_

Who is usually responsible for discipline? \_\_\_\_\_

How would you describe the effectiveness of parenting strategies in your home? \_\_\_\_\_

\_\_\_\_\_

Please check all that apply to your child:

- Quiet
- Sensitive to change in routine
- Daydreams
- Irritable
- Sensitive to certain clothing/textures
- Dislikes being touched
- Resistant to change
- Unusual sexual behavior
- Other: \_\_\_\_\_
- Happy
- Sensitive to loud noises
- Withdrawn
- Aggressive
- Unusual Fears
- Hyperactive
- Affectionate

Please describe the following characteristics in terms of whether the behavior never, sometimes or often occurs:

	Never	Sometimes	Often
Is your child active?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your child loud and noisy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have difficulty making transitions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your child sensitive to light?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your child sensitive to smells?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your child cry easily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your child clingy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can your child entertain him/herself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your child get angry easily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have temper-tantrums?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**Other Professionals:**

List other professionals (speech/language pathologists, psychologists, psychiatrists, neurologists, tutors, educational diagnosticians, etc.) your child has seen in the past or is currently seeing:

Name	Telephone Number	Dates Under Care In The Past	Current Appointment Days & Times	Reason for seeing

Has your child ever been in any type of special educational/therapy program, and if so, how long?

<input type="checkbox"/> Early Childhood Intervention (ECI)	Where	Duration
<input type="checkbox"/> PPCD Class	_____	_____
<input type="checkbox"/> Speech & Language Therapy	_____	_____
<input type="checkbox"/> Physical Therapy	_____	_____
<input type="checkbox"/> Occupational Therapy	_____	_____
<input type="checkbox"/> Psychotherapy	_____	_____
<input type="checkbox"/> Gifted and Talented	_____	_____
<input type="checkbox"/> Other (please specify) _____	_____	_____

**Please use this area for any additional comments or concerns:**

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---