STEP BY STEP CENTRE

APPLICATION FORM

Child's name:		**Date of birth:**	
Nationality:		**Language:**	
Religion:		**ID Number:**	
Father's name:		**Phone/Mobile:**	
Father's occupation:		**Father's Email:**	
Mother's name:		**Phone/Mobile:**	
Mother's occupation:		**Mother's Email:**	
Residential Address:		**Fax:** **PO Box:**	

EMERGENCY CONTACT DETAILS:

Person (s) to be contacted in case of emergency and to give consent for treatment:

Name: _____ Relationship: _____

Address: _____ _____Phone:_____

Personal physician:

_____

Name Address Phone

Preferred Hospital: _____

Insurance Information (Name and Telephone Number of Healthcare Provider):

_____

THIS SECTION WILL BE FILLED BY SBS OFFICE:

Applying for: School Admission ☐ Afternoon Therapy ☐ Assessment only ☐

Start Date:_____

Assessment is required: SLT☐ OT☐ ABA☐ SEN☐ DYS☐ Overall (SLT & OT & BA)☐ Other_____☐

Parents will provide an overall assessment report. ☐

Parents will provide the following assessment report/s: SLT ☐ OT☐ BA☐

Please also enclose two photographs, your child's passport copy, any medical, educational or other relevant documents.

Thank you for answering the following questions to the best of your knowledge. This information, which will be kept strictly confidential, will help us to understand your child.

FAMILY INFORMATION

1. Who lives in the household with your child?

Name	Age	Relation

2. Who looks after the child most of the time? _____

PREGNANCY

1. Do you know of any hereditary or congenital diseases in your family, father's or mother's side?

_____

2. During pregnancy, were there any medical complications, mental or emotional strains?

BIRTH AND INFANCY

1. Length of Pregnancy _____ (b) Birth weight: _____kg

2. Describe birth, easy or difficult?

_____

3. Did the baby require any special treatment after birth?

_____

4. How was your baby fed during the first year of life?

_____

5. Were there any disturbances of digestion, recurrent vomiting, unusual sleep pattern or colic?

_____

DEVELOPMENTAL MILESTONES

1. At what age was:

First smile _____ Walking unaided _____

Reaching out for things _____ First word said _____

Teething _____ Speaking in sentences _____

Sitting unaided _____ Toilet trained by day _____by night?_____

Crawling _____

2. Were there any periods of regression, loss of speech?

_____

3. When and why did you become concerned that your child was not developing normally?

_____

4. What is your child's diagnosis? When and where was it first made?

_____

5. What do you, as parents, think was the cause of your child's difficulties?

_____

CHILDHOOD TO PRESENT

Communication

1. Describe your child's ability to communicate or speak?

_____

2. What other means are used (sign, gesture, or assistive device)?

_____

Behaviour

1. Has your child received special behavioural treatment or therapy, such as ABA (Applied Behavioural Analysis)? YES NO

If YES, did you find ABA helpful? Give details such as duration

_____

2. Describe any self-stimulatory behaviours and/or aggressive behaviours, bad habits, obsessions etc.

_____

3. When does the inappropriate behaviour(s) usually occur (what conditions/situations)?

_____

4. What do you do to discipline your child and how does your child react to discipline?

_____

5. Describe your child's self-care and toileting habits (teeth brushing, washing, toilet trained, etc.)

_____

6. How many hours per day does your child watch TV, movies, or play on iPad, computer/video games?

_____

Eating habits

1. Describe eating habits (use of utensils, how your child relates to food/meal times)

_____

2. What does your child usually eat for Breakfast, Lunch, and Dinner?

_____

3. Is your child on a special diet? What is the reason for the special diet?

_____

4. Does your child have any allergies? ***(If so, please inform our office and request a medical information form.)***

_____

Sleeping habits

Describe sleeping habits (bedtime, naps during the day, how long etc.)

_____

Medical

1. What serious illnesses or childhood diseases or accidents has your child had, and at what age?

_____

_____

2. Has your child had any seizures? Please describe type, duration, and frequency.
(If so, please inform our office and request a medical information form.)

_____

3. Has your child been prescribed or given any unconventional treatments—special diets, supplements, vitamins, homeopathy etc.?

_____

4. Has your child seen a psychologist, psychiatrist, or other mental health professional? If so, please state reason, place and date.

_____

Social

1. How would you describe your child as a person?

_____

2. . What are his strengths and needs?

_____

3. . What does your child like to do (hobbies/interests) and what kinds of things scare or worry your child?

_____

4. How does your child get along with mother, father, and other children/family members? Does your child show normal affection? How does your child relate to peers?

_____

5. Please check (√) any of the following which concern you about your child:

Toilet Issues		Shy		Aggressive/ self		Purposely destroys things	
Too restless		Sad/moody		Temper Tantrums		Attention seeking	
Thumb sucking		Selfish in Sharing		Contrary or stubborn		Day dreaming	
Stammering or stuttering		Jealous		Disobedient		Sleep issues	
Easily upset		Aggressive /others		Lying		Feeding issues	

Education

1. Has your child been schooled before? Please state which and what type of school (SEN or regular) and what grade.

_____

2. Did your child receive any additional support, special programmes or Individual Education Plan?

_____

3. Does your child presently receive any therapy services? How often?

_____

4. Please describe your child's academic abilities.

_____

5. If any unusual progress or regression took place during school attendance and/or transitions, please describe.

_____

PARENT INVOLVEMENT

How would you like to be involved in your child's education (e.g. parent teacher evenings, parent workshops, parent groups, volunteering for events, etc.)

_____

This form is completed by _____

Relationship to child _____

*Date*_____