New Vision Children's Services
Hope and Healing

Client Registration

Mother's/Guardian's Name:	
Step-father/Guardian's Name:	
Father's/Guardian's Name:	
Step-mother/Guardian's Name:	
Physical Address:	
How long at this address? ______ mo ______years	
Home Phone #:	
Work Phone #:	(mother/father)
Cellular #: (mother)	Cellular #: (father)
Additional Address (please specify, such as shared custody):	
2nd Home #:	
Additional cellular #s:	
primary e-mail address:	
additional e-mail addresses (optional)	
# of children at home:	
Health Insurance? Yes No	
If yes, name of insurance company:	
HMO or PPO	

How did you hear about the center?
websearch   school district   physician   Inland Regional   daycare   e-mail list
other: ____

What kind of help does your child and/or your family need?

_____Direct therapy for my child (speech/language, OT, etc)
_____Help with IEP process
_____Assistance finding resources
_____Biomedical help
_____I think my child may have autism
_____Parent support group
_____Social Skills training
_____other:____

Child #1

Name: ______________________________Date of Birth: _________ Age: ____________

School of Attendance: _________________________________ Grade: ___________

School District: ____

In a special program: (specify) ______________________ on an IEP? Yes No

If yes, qualifying disability on IEP ____

Does child have (please circle those that apply):

Regressive autism Classic autism Asperger's Disorder ADD ADHD Tourette's
Sensory Integration Disorder Bipolar Disorder other: (specify) _____________

Food allergies eczema asthma sleep problems food intolerances
purple/black under eyes distended belly toileting issues

If autism spectrum disorder, date of diagnosis: ____________________________
By whom:____

Child #2

Name: ____ Age: ____________

School of Attendance: _________________________________ Grade: ___________

School District: ____

In a special program: (specify) ______________________ on an IEP? Yes No

If yes, qualifying disability on IEP ____

Does child have (please circle those that apply):

Regressive autism Classic autism Asperger's Disorder ADD ADHD Tourette's
Sensory Integration Disorder Bipolar Disorder other: (specify) _____________

Food allergies eczema asthma sleep problems food intolerances
purple/black under eyes distended belly toileting issues

If autism spectrum disorder, date of diagnosis: ____________________________
By whom:____

Child #3

Name: ____ Age: ____________

School of Attendance: ________________________________ Grade: ___________

School District: ____

In a special program: (specify) ______________________ on an IEP? Yes No

If yes, qualifying disability on IEP ____

Does child have (please circle those that apply):

Regressive autism Classic autism Asperger's Disorder ADD ADHD Tourette's
Sensory Integration Disorder Bipolar Disorder other: (specify) _____________

Food allergies eczema asthma sleep problems food intolerances
purple/black under eyes distended belly toileting issues

If autism spectrum disorder, date of diagnosis: ____________________________
By whom:____

Child #4

Name: ____ Age: ____________

School of Attendance: ________________________________ Grade: ___________

School District: ____

In a special program: (specify) ______________________ on an IEP? Yes No

If yes, qualifying disability on IEP ____

Does child have (please circle those that apply):

Regressive autism Classic autism Asperger's Disorder ADD ADHD Tourette's
Sensory Integration Disorder Bipolar Disorder other: (specify) _____________

Food allergies eczema asthma sleep problems food intolerances
purple/black under eyes distended belly toileting issues

If autism spectrum disorder, date of diagnosis: ____________________________
By whom:____