568 Communipaw Ave.
Jersey City, NJ 07305
(T)201.309.0198
LM4SDJC@gmail.com
www.LM4SD.com

CLASS REGISTRATION FORM

Which specialty CLASSES are you currently seeking for your child? (Please check all that apply)

- ☐ Social Skills
- ☐ Baby Sign Language & Speech
- ☐ Tummy Time
- ☐ Picky Eating
- ☐ Handwriting
- ☐ Music & Movement

Which specialty SERVICES are you currently seeking for your child? (Please check all that apply)

- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ ABA Therapy
- ☐ Music Therapy

Child's Full Name (Last, First):____

Date of Birth:___/___/____ Age: ____ Sex: F M

Parent/Guardian Name: (Mr./Ms./Miss)____

Home Address:____

____

Primary Contact#: (_____)_______-_________
Please Circle: (Home/Work/Cell)
Email: _________________________________

Secondary Contact: (____)______-_________
Please Circle: (Home/Work/Cell)
Email: _________________________________

568 Communipaw Ave.
Jersey City, NJ 07304
(T)201.309.0198
LM4SDjc@gmail.com
www.LM4SD.com

CLIENT INFORMATION & PARENT QUESTIONNAIRE

Please provide us with the following information so we can best serve your family.

Child's Full Name (Last, First):____

Date of Birth:___/___/____ Age: _____ Sex: F M

Parent/Guardian Name: (Mr./Ms./Miss)____
(Mr./Ms./Miss)____

Marital Status: ______________________ Language(s) Spoken: _________________________

Sibling Names: ____
____

Home Address:____
____

Primary Contact#: (_____)_______-_________
Please Circle: (Home/Work/Cell)
Email: _________________________________

Secondary Contact: (____)______-_________
Please Circle: (Home/Work/Cell)
Email: ________________________________

Would you like to receive e-mails regarding upcoming workshops, programs, and special events? Yes ☐ No ☐

Person Responsible for Bill: ____

Date of Birth:_____________ Address (If Different):____________________________________

Phone Number (If Different): (___)______-_________ Work Number: (___)______-_________

Employer's Name: ____

Employer's Address: ____

How did you learn about Little Milestones for Small Discoveries?

____

Reference's Name (If Any):

____

568 Communipaw Ave.
Jersey City, NJ 07304
(T)201.309.0198
LM4SDjc@gmail.com
www.LM4SD.com

Child's Physician(s)

____

Other Health Professionals, Agencies, or Medical Professionals working with your child?

____

____

____

List current school or childcare provider:

____

____

List previous school/daycare experiences:

____

____

If your child receives services in school, please list them here (i.e. OT, PT, Speech):

____

____

TELL US MORE ABOUT YOUR CHILD

Please answer the following to the best of your knowledge:

Describe your child's developmental milestones (walking age, talking age, social skills):

____

____

____

What are your child's strengths?

____

____

____

What do you find difficult for your child to accomplish?

____

____

568 Communipaw Ave.
Jersey City, NJ 07304
(T)201.309.0198
LM4SDjc@gmail.com
www.LM4SD.com

Does your child have a hard time understanding or following directions?

____

____

Describe how your child gets along with other children?

____

____

____

YOUR CHILD'S LIKES/DISLIKES

Please answer the following to the best of your knowledge:

What are some things your child dislikes?

____

____

Please list your child's favorite play activities/toys?

____

____

What are your child's favorite foods?

____

____

Is your child a picky eater? Yes ☐ No ☐ If so, please explain below:

____

____

YOUR CHILD'S PAST MEDICAL HISTORY

Please answer the following to the best of your knowledge:

Has your child had any ear infections? Yes ☐ No ☐
If so, please indicate how often and how they were treated for it below:

____

____

568 Communipaw Ave.
Jersey City, NJ 07304
(T)201.309.0198
LM4SDjc@gmail.com
www.LM4SD.com

Does your child seem overly sensitive to noises, light, crowds, texture/touch, clothing, (etc.)
Yes ☐ No ☐ If so, please describe below:

____

____

____

Please describe any family history of health, mental, emotional, or learning difficulties:

____

____

____

YOUR COMMENTS/CONCERNS

Please answer the following to the best of your knowledge:

(**Picking Eating Class**) Please describe any mealtime routines or concerns:

____

____

____

____

(**Handwriting Class**) Please describe any handwriting concerns:

____

____

____

____

Please tell us your GOALS for this specialty class :

____

____

____

568 Communipaw Ave.
Jersey City, NJ 07304
(T)201.309.0198
LM4SDjc@gmail.com
www.LM4SD.com

PERMISSION TO USE PHOTOGRAPH & VIDEOGRAPHY

Please initial on eof the following boxes to address photography and videography as a client of Little Milestones for Small Discoveries, LLC.

☐ I hereby consent Little Milestones for Small Discoveries, LLC, its representatives and its employees the permission to take photographs of my child: ___________________________.
I also grant Little Milestones for Small Discoveries, LLC, the right to edit, use, and reuse photos and videos in print, on the internet, and all other forms of media and marketing. I agree that Little Milestones for Small Discoveries, LLC, may use such photographs/videos fo my child for therapeutic intervention purposes, learning purposes, publicity, illustration, advertising, and web design/content. I hereby release Little Milestones for Small Discoveries, LLC, and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

☐ I DO NOT give permission to Little Milestones for Small Discoveries LLC, its representatives and employees, the right to take photographs and/or videos of my child.

___________________________.

I have read and understand the above:

Signature of Parent/Guardian:

____

Parent/Guardian Name (Print): ____

Address of Parent/Guardian: ____

Child's Name (Print): ____

Date: ____