



APPLICATION

DATE: ____/____/____

Child's Information

Child's Name: _____ Birth date: ____/____/____ Gender: *M F*

Address: _____ City: _____

State: _____ Zip: _____ Phone #: _____

e-mail _____ Pediatrician _____

Please list any major medical problems: _____

Does your child have a developmental diagnosis? _____

If yes, what is the diagnosis? : _____

Age of child at initial diagnosis: ____ years ____ months

Who made the diagnosis? _____

Family Information

Mother's Name: _____ Birth date: ____/____/____ Occupation: _____

Schooling: *Non-High School Grad High School Grad Some College College Grad Post-Grad*

Father's Name: _____ Birth date: ____/____/____ Occupation: _____

Schooling: *Non-High School Grad High School Grad Some College College Grad Post-Grad*

Marital Status: *Married Divorced Separated Single Living Together Widowed Other* _____

Other Caregiver's Name: _____ Birth date: ____/____/____ Occupation: _____

Schooling: *Non-High School Grad High School Grad Some College College Grad Post-Grad*

Names and ages of siblings: _____

List the names of those living in the household other than the immediate family:

Is there anything else you would like us to know about your family?

Educational Information

B. Education

Is your child in a Birth to Three Program? *YES NO* School District Program? *YES NO*

Agency or School Name: _____ District: _____

Address: _____ City: _____ State: _____ Zip: _____

Age when first enrolled in either of the above? .: _____ years _____ months

_____ *Please total the number of hours your child spends in an early intervention program per week.*

Is your child enrolled in a community preschool program ? *YES NO*

If “yes”, what are the days and times? _____

C. Therapies/Interventions

Please complete the following chart.

Therapy/Intervention	Agency	Start Date	Frequency	Session Length

_____ *Please total the number of hours per week of all therapies outside of school.*

A. Parent Involvement

Are you familiar with DIR / Floortime Techniques? *YES NO*

Are you using these with your child? *YES NO*

_____ *If yes, please estimate the number of hours per week.*

B. Other Information

Is there anything else you would like to tell us about your child?

Please return to:

Family First

Box 75

Rowayton, CT 06853