

**BRIDGES at The Therapy Place
DEVELOPMENTAL SCREEN**



Basic Contact Information

Child's Name	
Child's DOB	
Parent's Name	
Mailing Address	
Email Address	
Phone Number	
How did you hear about the Bridges program?	

Medical Screening

Does your child have any of the following concerns:

Child's Diagnosis/es			
Heart Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Type I <input type="checkbox"/> Type II
Gastric feeding tube	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Tracheotomy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Allergies (Food or otherwise)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please list:
Controlled or uncontrolled seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Check here if history of seizures. Date of last seizure: Medications used for seizures management: Procedures when child has a seizure:
Other health/medical conditions that require special attention or medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
List any insurance plan(s) by which your child is covered			

*Tuition for the Bridges Preschool program is private pay and not covered by any insurance; however, the therapies your child would be receiving while in the program are covered. The Therapy Place is a Medicaid-based facility meaning that we only "take" Medicaid plans. Those plans are Regular/TEFRA/Fee-for-Service Medicaid, Absolute, and BlueChoice Medicaid. If your child has a different Medicaid or private insurance only, please let us know so that we can discuss options.

Developmental Screening

Current Therapies

Please list provider(s) & frequency

Speech Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Physical Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Occupational Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Early Intervention (EI)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other <i>please specify</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Gross Motor

Additional Comments

Sits unassisted	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Crawls	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Stands unsupported	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Walks unassisted	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Uses assistance to walk/move (gait trainer, AFOs, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please list:

Fine Motor

Grasps hand-size object with right hand	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Grasps hand-size object with left hand	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Grasps pea-size object with right hand	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Grasps pea-size object with left hand	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Adaptive/Self-Help

Bites and chews hard & chewy foods	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Drinks from cup or glass unassisted	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If no, what does child use? (bottle, sippy cup, etc.):
Eats with fork/spoon unassisted	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Eats with fingers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Lets others know when he/she has to potty	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Uses toilet unassisted	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Indicates awareness of soiled/wet diaper/pants	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Food aversions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Communication

Babbles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Points or gestures appropriately	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Uses signs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Uses words	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
How does your child primarily get his/her wants/needs met? (words, signs, pointing, etc.)			

Cognitive

Recognizes own name	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Carries out one-step directions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Social

Initiates & maintains interaction with familiar adult	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Initiates & maintains interaction with peer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Entertains self by playing appropriately with toys	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Please use area below to elaborate on your child. What are your child likes and dislikes? How does he/she get around, communicate, play? Does your child like to be around other children? What else should we know about your child? Feel free to attach an additional sheet, if necessary.

Upon receipt of this screen, a parent tour will be scheduled to further discuss the Bridges Program and answer any questions.