The FieldCenter
for Children's Integrated Development

FELDENKRAIS® FOR CHILDREN
83 Park Street, Montclair, NJ 07042 134 West 26th Street, New York, NY 10001
info@thefieldcenter.org 973-655-0385
thefieldcenter.org

Today's Date:

Full Name of child:

Date of birth:

Was your child born prematurely?
Yes/No

If so, what week?

Weight/Length at birth?

Gender:
M/F

Current Height:

Current Weight:

Current Age:

Name of Parents:

Other Caregivers:

Siblings (note age):

Street Address:

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City:

Zip Code:

Home phone:

Work phone:

Mobile phone:

E-mail address:

May we add your email to our e-mail list?
Yes/No

Emergency contact:

Name/relationship:

Phone number:

Child's school's name:

Address and phone number:

Have you consulted an attorney regarding your child's diagnosis?
Yes/No

If yes, provide the attorney's name(s), the firm name(s), the address (es), and the telephone number(s):

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Is your relationship with the attorney ongoing?
Yes/No

What is your child's diagnosis?

When was your child diagnosed?

Who diagnosed your child?

Where was your child's diagnosis made?

Facility:
City:
State:

How was your child's diagnosis made (observation/tests)?

Describe the progression that led to your child's diagnosis (use separate sheet if necessary):

What do *you* believe caused or is responsible for your child's diagnosis?

Please describe your child's current abilities:

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Please describe your child's current symptoms/difficulties:

Is your child in pain? If so, describe circumstance and treatment:

Has your child had surgery? If so, please describe. When was the surgery done? Who was the surgeon? Are subsequent surgeries anticipated?

Has your child had seizures? Yes/No
If yes, please give a detailed description of condition past and present:

List all medications used in treatment:

What medications does your child currently take? What condition is the medication treating? Is the medication effective? How is the dose

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regulated?

Please describe your child's sleeping and eating routines:

What is your child's typical daily schedule? Please include school, special programs, therapy appointments, and etc.:

What equipment or supportive devices does your child use or rely on?

List all CURRENT doctors and other health care providers who have treated your child in relation to the diagnosis you have come here to discuss. Please include their names, addresses, and telephone numbers:

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What other forms of interventions (traditional and/or complimentary) has your child sought in the past 2 years or are currently engaged in?

Please describe why you are seeking our services:

How did you learn about The Field Center?

Anything else you would like to add?

Please attach relevant and current medical evaluations (pediatrician, pediatric neurologist, orthopedist, physical medicine, nutritionist, surgeon, acupuncturist, other):

Please include a picture of your child, if possible:

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Please email the form to info@thefieldcenter.org, putting the child's name in the subject line. Please bring a printed version of the form along with other relevant documentation to your first appointment or mail it to: Attn: Sheryl Field, 83 Park Street, Montclair, NJ 07042

All information provided is kept strictly confidentially and is collected to best meet the needs of your child.