DATE\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- |
| Child’s Last Name | First Name | Middle | Birth date | Age | Gender  M  F |

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| --- | --- | --- | --- | --- |
| Name of Person Completing Form | | Phone | | |
| Street Address | | City | | State | Zip Code | |

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| --- |
| Who referred you to me? |

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| --- |
| Presenting problem, reason for referral |
| What do you like to learn or have happen from your consultation or evaluation with me? |

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| --- | --- | --- | --- | --- |
| Are parents (check one) | married | separated | divorced | never married |
| For how many years? |  |  |  |  |
| Custody  Arrangement  (if applicable) |  | | | | |

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| --- | --- | --- | --- | --- | --- |
| Who lives at home with this child? | | | | | |
| Name | Relationship | Age | Ethnicity | Occupation/Schooling | Level of  Education |
|  |  |  |  |  |  |
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| If child lives in more than one household, please describe the other household: | | | | | |
| Name | Relationship | Age | Ethnicity | Occupation/Schooling | Level of  Education |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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| If child is ADOPTED, age child was first in home: \_\_     \_\_\_\_\_\_\_\_ Date of legal adoption: \_     \_\_\_\_\_\_\_\_\_\_ |

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| If child spends a significant amount of time with a caregiver other than someone described above (more than 4 hours) EXCLUDING educators, please complete the following information for that person here:  Name:       Age:  Relationship to child:       Ethnic/Cultural Background:  Occupation:       Highest Level Education: |

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| Have any members of the biological mother’s or biological father’s families had any of the following problems or disorders (check all that apply):  Birth Defect Cerebral Palsy Chromosome/Genetic Disorder  Physical Handicap Seizures/Epilepsy Tuberous Sclerosis  Severe Head Injury Autism/PDD Mental Retardation Food Allergies Migraines  Nervousness/Anxiety Depression Obsessive Compulsive Disorder Bipolar-manic-depressive disorder Schizophrenia Emotional Disturbance  Tics/Tourettes syndrome ADHD    Childhood Behavior Disorder (aggressive/deviant/ADHD) Antisocial Behavior (assaults, theft, arrest)  Alcohol/Drug Abuse  Other Problems (explain) |

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| Please indicate any major family stressors the family and/or child is currently experiencing or has experienced within the last year:  Marital discord/fighting Separation Divorce  Birth/Adoption of another child Sibling conflict Parent-child conflict  Custody disagreement Single-parent family Parent-sibling death  Parent deployed extensively Parent emotionally/mentally ill Legal problems  Child neglect Physical abuse Sexual abuse  Health problems Financial problems  Parental disagreement about child-rearing  Involved with Social Services/Child Protective Services  Other stress, if not listed:  Please describe stress listed above: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type of Labor  Spontaneous  Induced | Problems During Delivery  cord around neck  hemorrhage  injury:  other: | Type of Delivery  Normal  Breech  Caesarean | Birth Weight | APGARS |
| Duration of Labor        hours |

|  |  |  |
| --- | --- | --- |
| Problems During Pregnancy  excessive nausea/vomiting toxemia  operations threatened miscarriage  infections emotional problems  excessive blood loss rashes  difficulty conceiving excessive swelling  kidney disease rh incompatibility  urinary problems anemia  vaginal bleeding  on bed rest  headaches  high blood pressure  other illness (describe): | During Pregnancy  smoking:     cigarettes/day  alcohol:      drinks/week  medications:  special diet:    received prenatal care  no prenatal care | Mother’s age at conception    Prior mis-carriages?  N Y  Length of Pregnancy       weeks |

|  |
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| Post Delivery Problems  jaundice cyanosis (turned blue) infection incubator care  remained in hospital: \_      days |

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| Infancy Problems (birth to one year)  irritability feeding problems restless did not enjoy cuddling difficult to comfort  breathing problems  seizures/convulsions head banging not sleeping excessive crying |

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| From age one to four years, were there any special problems noted in the following areas?  Irritability Breathing Problems Colic  Difficulty sleeping Eating problems Temper tantrums  Failure to thrive Excessive crying  Withdrawn behavior  Poor eye contact Early learning problems Destructive behavior  Convulsions/Seizures Twitching Unable to separate from parent  Other: |

|  |
| --- |
| When did child (or has s/he not): |
|  | has not | age in months when first did |
| Smile |  |  |
| sit without support |  |  |
| Crawl |  |  |
| stand without support |  |  |
| walk without help |  |  |
| Babble to communicate |  |  |
| Use single words |  |  |
| Use 2-3 word phrases |  |  |
| become bladder trained during day |  |  |
| become bladder trained during night |  |  |
| become bowel trained |  |  |
| started solid food |  |  |
| feed self with spoon |  |  |
| ride tricycle |  |  |

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| Has your child ever lost skills, which at one time he/she was able to perform? No Yes  If yes, please explain: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| School Name, Address, District |  | | | |
| Grade |
| Type of Class |  | | | |
| Current # of Students \_     \_\_\_Teachers      \_\_\_ Aides\_     \_\_\_\_\_\_\_ | | | | Does your child have a 1:1 aide? | |
| What special services is your child receiving in school? How many hours? Individual or group?  Speech therapy \_\_      Occupational therapy  Physical therapy       Adaptive PE  Social skills \_      Counseling  Other (describe): | | | | |
| Relationship With  Teachers |  | | | |
| Relationship With  Peers |  | | | |
| Behavior Problems  In Class |  | | | |
| Are you satisfied with the school placement? What are the strengths and weaknesses? | | | | | |
| Describe any other services your child is receiving privately | | | | |
|  | | Where | How many hours? Benefits? | |
| Speech Therapy | |  |  | |
| Occupational Therapy | |  |  | |
| Physical Therapy | |  |  | |
| Social Skills Training | |  |  | |
| Counseling | |  |  | |
| Other | |  |  | |

|  |
| --- |
| Please check and describe CURRENT problem areas:  □ Eating \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Sleep \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Mood/Emotions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Attention \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Dealing With Change \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Activity Level \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Tantrums \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Aggression \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Self-Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Unusual Acts \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Repetitive Behaviors \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| Describe how child relates | |
| To parents |  | |
| To siblings |  | |
| To adults outside family |  | |
| Describe how child usually spends free time | | |

|  |
| --- |
| Describe how child gets what s/he wants |

|  |
| --- |
| Describe how child is disciplined and by whom |

|  |
| --- |
| Describe the best things about your child, strengths, and good qualities |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Pediatrician Name | Street Address | City, State | Zip code | Phone | Last Seen |

Send final report to pediatrician? \_\_\_\_\_\_ Yes \_\_\_\_\_ No

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of Current Medications and Dosage | | | Target Symptoms | | Effectiveness |
|  | | |  | |  |
|  | | |  | |  |
|  | | |  | |  |
| Prescribing physician for above medications | | | Phone number | | Date of last visit |
| Medications tried in past: | | | Target Symptoms | | Effectiveness |
|  | | |  | |  |
|  | | |  | |  |
| Has your child ever had: |
|  | has not | age first occurred | | Describe | | |
| an operation |  |  | |  | | |
| a hospitalization |  |  | |  | | |
| seizures |  |  | |  | | |
| loss of consciousness |  |  | |  | | |
| frequent high fevers |  |  | |  | | |
| eye problems |  |  | |  | | |
| tics |  |  | |  | | |
| ear infections/tubes |  |  | |  | | |
| allergies |  |  | |  | | |
| Any other health problems? | Has not | Age first occurred | | Describe | | |

|  |
| --- |
| Doctors Seen (check all that apply and please provide copy of reports)  Name Date Seen Testing Results/Diagnosis |
| □ Developmental Lead Testing  Pediatrician |
| □ Neurologist MRI  EEG |
| □ Geneticist |
| □ Gastroenterologist |
| □ Psychiatrist/ Psych. testing  Psychologist |
| □ Audiologist |
| □ Other |

***Thank you for your time and patience in completing this form! Please bring copies of all prior reports. This information will be a great help to me in evaluating your child.***