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

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

|  |  |
| --- | --- |
| 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  |

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

|  |
| --- |
| 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 YesIf 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 WithPeers |       |
| Behavior ProblemsIn 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 |       |       |

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| 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| --- |
| 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.***