BACKGROUND INFORMATION: Date:_____

Child's Name: _____

Date of Birth: _____Chronological Age:_____

School: _____Grade_____

Mother's Name: _____

Address: _____

_____

Home Telephone: _____Work Telephone:_____

Occupation: _____

Father's Name: _____

Address: _____

_____

Home Telephone: _____Work Telephone:_____

Occupation: _____

Marital Status of Parents: Single_____Married_____Divorced____Widowed____

If divorced, what is custody agreement? _____

REFERRAL INFORMATION:

Referred By: _____

Describe the reasons you are requesting this evaluation of your child. If possible, list specific questions for which answers are sought.

_____

_____

Language(s) spoken if not English: _____

List all people now living in your household, then draw a line and list others who have lived with the child. (Please note dates)

NAME	RELATIONSHIP TO CHILD	AGE	HIGHEST SCHOOL GRADE ATTENDED	OCCUPATION

Please indicate if any children in the household were adopted and dates of any previous marriages, divorces, or remarriages of parents. Describe any custody arrangements. Describe any deaths in the immediate family. Note any unusual family circumstances.

_____

_____

_____

_____

_____

_____

_____

Pediatrician: _____

Address: _____

Telephone: _____

Permission to speak with pediatrician: Yes_____ No_____

PREGNANCY AND BIRTH HISTORY:

Describe any complications that occurred during pregnancy (i.e. weight loss, illness, high blood pressure, spotting, false labor, etc)?

Was the baby born premature?_____Late?_____If so, how much?_____

Labor induced?_____Caesarean delivery?_____Length of Labor?_____

Forceps used?_____Breech birth?_____If in incubator how long?_____

Did baby receive oxygen?_____Jaundiced?_____Bilirubin lights?_____

Length of stay in hospital: Mother?_____Child?_____

Describe any other complications that occurred during delivery.

Birth weight?_____How long after birth did you take your baby home?_____

Describe the baby's condition at birth:

EARLY TEMPERAMENT:

Describe the child's temperament during the first 6 months (i.e., sleep patterns, colic, eating patterns)

DEVELOPMENTAL HISTORY: (Note the approximate ages of the following:)

Sitting unsupported:_____ Walking alone:_____

Using single words:_____ Using two or more words together:_____

Toileting: Urine daytime:_____ Nighttime:_____

Bowel daytime:_____ Nighttime:_____

Which hand does your child prefer? Right_____ Left_____ Age established_____

MEDICAL HISTORY:

List sicknesses (i.e., frequent ear infections, operations, and injuries). Include the age when they occurred and severity. Please pay special attention to head injuries, any loss of consciousness, convulsing, or very high fever.

_____

_____

_____

_____

Did anyone in your immediate family or close relative have any of the following?

Nervous tics	Yes___	No___	Who_____
Seizures (epilepsy)	Yes___	No___	Who_____
Emotional problems	Yes___	No___	Who_____
Hyperactivity	Yes___	No___	Who_____
Learning problems	Yes___	No___	Who_____
Language problems	Yes___	No___	Who_____
Mental retardation	Yes___	No___	Who_____
Left-handedness	Yes___	No___	Who_____
Similar problems to child	Yes___	No___	Who_____

Does any disease run in the family? If so, what?_____

Past medications: (indicate dosage, physician, and reason it was taken):_____

_____

_____

Current medications: (indicate dosage, physician, and reason taking):_____

_____

_____

_____

Has your child's vision been examined?_____Date:_____

If so, by whom?_____

Results:_____

Has your child's hearing been examined? _____Date:_____

Results:_____

Other special medical tests (EEG, CAT Scan, MRI):

Name of Test:_____Date:_____

Results:_____

Previous psychological or neurological evaluations: (List names, addresses, dates, and any pertinent reports)

_____

_____

Psychiatric hospitalizations: (List names, addresses, dates, etc.)_____

_____

Psychotherapy: (List names, addresses, dates, etc.)_____

_____

_____

SOCIAL-EMOTONAL/BEHAVIORAL HISTORY:

List your child's personality characteristics, both positive and negative:

Describe current eating and sleeping patterns.

Note any particular behavioral concerns (i.e., eating habits, sleeping patterns, level of activity, sibling relationships, peer relationships, moodiness, attending difficulties, destructiveness, unusual habits, fears, tenseness, etc.):

Describe fine and gross motor skills, as well as any problems with awkwardness or clumsiness.

Describe vigor and/or activity level.

Describe any unusual or intense fears or shyness.

Describe any unusual behaviors, rituals, habits, etc.

Describe any moody periods.

What do you find most difficult about raising your child?

What is your child's usual disposition?

Current discipline techniques:

Who disciplines?

Do parents agree on how to discipline?

How does your child respond to discipline?

Please check the behaviors that apply and add any comments you feel would be beneficial in our evaluation:

Behavior	Comments
_____Short attention span or concentration	
_____Forgetful	
_____Restless (overactive)	
_____Aggressive	
_____Difficulty following directions	
_____Difficulty with authority	
_____Lacks confidence in self	
_____Temper Tantrums	
_____Speech difficulties	
_____Displays immature behavior	
_____Daydreams excessively	
_____Constantly seeks teacher attention	
_____Withdrawn	
_____Poor eye-hand coordination	
_____Slow in completing work	
_____Right-left confusion	
_____Limited vocabulary	
_____Impulsive	
_____Difficulty expressing emotions appropriately	
_____Poor eye contact	
_____Accident Prone	
_____Bites nails	
_____Has tics or twitches	

Describe your child's relationship with the following:

Peers _____

_____

_____

Siblings _____

_____

_____

Mother _____

_____

_____

Father_____

_____

_____

Adults in general _____

_____

_____

Significant others_____

_____

_____

What activities does your child enjoy? (sports, hobbies, interests, etc.)

_____

_____

_____

What are your child's strengths? What do you enjoy most about your child?

SCHOOL HISTORY:

List previous schools attended with dates (include nursery and preschools):

List current teachers and subjects taught:

Describe any learning/behavioral/social difficulties at school:

Public School services: (List date placed and services received)

Early Intervention program:_____

_____

Learning Disability/O.H.I./Student Support Team:_____

_____

Speech and language services:_____

_____

Occupational therapy services:_____

_____

Private services: (List date placed, services received, and phone number)

Tutoring:_____

_____

Speech/language therapy:_____

_____

Occupational therapy:_____

_____

If your child attends a private school, do they participate in any specialized programs through the school for learning support? If so, describe:_____

_____

_____

Permission to talk with school: Yes_____No_____

Permission to talk with tutors or therapists listed above: Yes_____No_____

Has your child ever repeated a grade?_____If so, when?_____

What was the reason?_____

_____

List the grades from the most recent report card or attach a copy:

_____

_____

You will receive copies of your child's report to distribute to various school personnel and physicians. If you wish a report of findings to be sent directly from our office to a physician, school or other child agency, please indicate to whom:

_____

_____

Please feel free to add any additional comments which you feel will be helpful on the attached page.

I very much appreciate the trouble to which you have gone in filling out this questionnaire. Please add any additional comments on the next page.

Signed:_____

Additional comments: