

List any serious illnesses, injuries, hospitalizations, surgeries, or traumatic events (e.g., diabetes, seizures, convulsions, concussions, asthma, allergies, etc.) Child's Age at the Time

Current Medical Diagnosis Medical Provider's Name Date of Diagnosis Prescribed Medication

**Please attach any pertinent physician reports or diagnostic statements*

Does the child have a family history (biological parents, siblings, grandparents, aunts, uncles, cousins) of any of the following?

- Learning difficulties (reading, spelling, writing, math, organization)
- Speech or language difficulties (articulation, stuttering, organizing/recalling words, etc.)
- Emotional difficulties (depression, anxiety, mood disorder, psychosis, etc.)
- Cognitive difficulties (may have been called mental retardation or mental handicap)
- Genetic medical conditions impacting developmental, learning, and emotional health
- Abuses or domestic violence
- Substance abuse (drugs or alcohol)
- Other: _____

Does your child experience any of the following:

- Vision problems? Yes No Glasses? Yes No Contacts? Yes No
 Date of recent vision exam _____ Results _____
 Describe any vision sensitivity: _____
- Hearing problems? Yes No Age detected: _____ Tubes in ears? Yes No Date: _____
 Hearing aids? Yes No Cochlear implant? Yes No
 Date of recent hearing exam _____ Results _____
 Describe any hearing sensitivity: _____
- Sleep problems? Yes No Describe: _____
- Taste problems? Yes No Describe: _____
- Touch problems? Yes No Describe: _____
- Other: _____

What is your child's primary language? _____ What other languages are spoken at home? _____

Did the child demonstrate the following behaviors within an age-appropriate time line?

Behavior	Normal Age Range	
Rolled over	4-6 months	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/Not yet shown
Sat alone	6-9 months	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/Not yet shown
Crawled	6-9 months	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/Not yet shown
Stood alone	12-15 months	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/Not yet shown
Walked alone	12-15 months	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/Not yet shown
Babbled	6-9 months	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/Not yet shown
Spoke first word	9-12 months	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/Not yet shown
Combined words together	18-24 months	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/Not yet shown
Toilet trained during the day	22-24 months	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/Not yet shown

Please check early intervention services received when your child was a toddler: Speech and Language
 Developmental Therapy Physical Therapy Occupational Therapy Behavioral Therapy
 Other: _____

SCHOOL HISTORY

Daycare/Preschool/School Attended

Date of Attendance

If your child repeated a grade, what grade was repeated? _____ School: _____
Reason for retention? _____

Has your child received private interventions or evaluations to assist with school progress?

- Educational services from private entity (e.g., private tutor, Sylvan, Learning Rx, Lindamood Bell, etc.)
- Therapy services from private entity (e.g., speech, occupational therapy, physical therapy, vision therapy, behavioral therapy, etc.)
- Private evaluations/previous school evaluations (*please attach previous educational reports*)

Please describe the following:

Your child’s school strengths: _____

Your child’s school weaknesses: _____

Your child’s study habits at home: _____

Your child’s attitude toward school: _____

BEHAVIORAL HISTORY

Please check behaviors deemed to be a **significant** concern at this time:

- | | |
|---|--|
| <input type="checkbox"/> Fidgets, is easily distracted, | <input type="checkbox"/> Talks excessively, interrupts often, doesn’t listen |
| <input type="checkbox"/> Has a hard time staying seated | <input type="checkbox"/> Often loses things, very disorganized |
| <input type="checkbox"/> Shifts quickly from one activity to another | <input type="checkbox"/> Has difficulty waiting his/her turn or in line |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Difficulty initiating tasks |
| <input type="checkbox"/> Difficulty following instructions | <input type="checkbox"/> Difficulty completing tasks |
| <input type="checkbox"/> Difficulty playing quietly | <input type="checkbox"/> Often is loud |
| <input type="checkbox"/> Engages in impulsive behavior | <input type="checkbox"/> Engages in physically dangerous activities |
| <input type="checkbox"/> Immature compared to peers | <input type="checkbox"/> Difficulty making decisions |
| <input type="checkbox"/> Depressed/sad mood | <input type="checkbox"/> Feelings of worthlessness or low self-esteem |
| <input type="checkbox"/> Sleeping too little | <input type="checkbox"/> Sleeping too much |
| <input type="checkbox"/> Low energy/fatigue | <input type="checkbox"/> Repeatedly has nightmare/night terrors |
| <input type="checkbox"/> Excessive separation difficulties | <input type="checkbox"/> Shy/withdrawn |
| <input type="checkbox"/> Overly anxious or fearful | <input type="checkbox"/> Cries easily |
| <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Argumentative with: <input type="checkbox"/> adults <input type="checkbox"/> peers |
| <input type="checkbox"/> Rapid mood changes/mood swings | <input type="checkbox"/> Suicidal thoughts/acts |
| <input type="checkbox"/> Defies adult requests and rules | <input type="checkbox"/> Blames others for mistakes |
| <input type="checkbox"/> Deliberately annoys others | <input type="checkbox"/> Physically aggressive towards: <input type="checkbox"/> peers <input type="checkbox"/> adults |
| <input type="checkbox"/> Angry/resentful | <input type="checkbox"/> Easily frustrated |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Overeats |
| <input type="checkbox"/> Often complains about bodily aches | <input type="checkbox"/> Excessive worry about: <input type="checkbox"/> events <input type="checkbox"/> others |
| <input type="checkbox"/> Often is truant or late | <input type="checkbox"/> Excessive need for reassurance |
| <input type="checkbox"/> Lies | <input type="checkbox"/> Steals |
| <input type="checkbox"/> Substance abuse: <input type="checkbox"/> drugs <input type="checkbox"/> alcohol | <input type="checkbox"/> Often swears or uses obscene language |
| <input type="checkbox"/> Stereotyped mannerisms | <input type="checkbox"/> Compulsive rituals |
| <input type="checkbox"/> Atypical/unusual fascinations or thoughts | <input type="checkbox"/> Hallucinations: <input type="checkbox"/> Visual <input type="checkbox"/> Auditory |
| <input type="checkbox"/> Fire setting | <input type="checkbox"/> Self-mutilation/self-injury |
| <input type="checkbox"/> Destroys others’ property | <input type="checkbox"/> Harms animals |

Does your child display any of the atypical behavioral patterns?

- | | |
|---|---|
| <input type="checkbox"/> Preoccupation with specific topics or objects | <input type="checkbox"/> Eccentric forms of behavior |
| <input type="checkbox"/> Not understand or aware of others' views | <input type="checkbox"/> Atypical facial or emotion responses to situations |
| <input type="checkbox"/> Desires things to be in a specific way and routine | <input type="checkbox"/> Unusual mannerisms and ways to move body |
| <input type="checkbox"/> Trouble understanding jokes and humor | <input type="checkbox"/> Difficulty adjusting to new surroundings |
| <input type="checkbox"/> Difficulty adjusting to changes in plans/routines | <input type="checkbox"/> Other: |
-

Please indicate and specify reasons your child received the following:

- | | |
|--|-------|
| <input type="checkbox"/> Counseling | _____ |
| <input type="checkbox"/> Department of Children's Services | _____ |
| <input type="checkbox"/> Juvenile court or probation | _____ |
| <input type="checkbox"/> Mental health hospitalization | _____ |
| <input type="checkbox"/> Psychological evaluation | _____ |

*** Please attach relevant reports.**

SOCIAL HISTORY

How does your child get along with adults at home?

How does your child get along with siblings in the home?

How does your child get along with peers?

How many friends does your child have? _____ What activities does your child do with his/her friends?

What are your child's favorite activities?

What are your child's behavioral and social strengths?

What are your child's behavioral and social weaknesses?

Please indicate which occurred during the past year:

- | | |
|---|---|
| <input type="checkbox"/> Relocation to new city | <input type="checkbox"/> New home |
| <input type="checkbox"/> Loss of family member | <input type="checkbox"/> Illness of family member |
| <input type="checkbox"/> Change in family income | <input type="checkbox"/> Job change/loss |
| <input type="checkbox"/> New addition to the family | <input type="checkbox"/> Other (specify): |

Other information you believe may be relevant to in the evaluation of your child:
