Please fill out all applicable areas of this form. If you do not know the information or it does not pertain to your child, leave the area blank.

What is the main reason you are seeking evaluation at this time? What are the chief concerns that you would like help with?

_____

_____

_____

## I. General Information

| | | | |
|---|---|---|---|
| Child name (last, first) | Age | Grade | Birthdate |
| Person completing form | Relationship | | Today's date |
| Parent/Guardian | Home phone | | Work phone |
| Address | City | State | Zip |
| 2nd Parent/Guardian | Home phone | | Work phone |
| Address (if different) | City | State | Zip |
| Child's birthplace | Adopted? □Yes □No | | If child was adopted, age at adoption |

## II. Family Background:

A. Birth Parents: This section pertains to the child's biological parents only. If you are not the child's birth parent, please complete as accurately as you can.

| | |
|---|---|
| Birth mother's name: | Present age: |
| Highest level of formal education completed and degrees/certificates earned: | Current profession/occupation: |

| | |
|---|---|
| Live with child full time ☐ Yes ☐ No | Marital status:<br>☐ Married ☐ Separated ☐ Widowed<br>☐ Divorced ☐ Single, never married |
| Birth father's name: | Present age: |

| | |
|---|---|
| Highest level of formal education completed and Degrees/certificates earned: | Current profession/occupation: |
| Live with child full-time? ? Yes ? No | Marital status:<br>? Married ? Separated ? Widowed<br>? Divorced ? Single, never married |
| Child resides with:<br>? Birth mother & father ? Birth mother only<br>? Parent & stepparent ? Birth father only<br>? Parent & adoptive parent ? Adoptive parent(s)<br><br>Guns in the home ? Yes ? No<br>Second-hand smoke exposure? ? Yes ? No | If child lives with only one parent, contact with the other parent is:<br>? Frequent (sees child more than 4 days per week)<br>? Minimal (sees child less than once per week)<br>? None<br><br>If child lives with only one parent, does the other parent have permission to bring child for treatment?<br>? Yes ? No<br><br>Pets, include reptiles and small pets: |

B. **Siblings and Birth Order**: List the names and ages of each sibling in birth order, oldest child first, including relationship to the child (i.e., natural, half-sibling, step-sibling)

| Name: | Age: | Male/Female: | Relationship:(natural,half-sibling,step-sibling) |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

**C. Family History**

Please check all that apply.

| **Condition** | **Patient** | **Relative** | **Comments: please indicate any details regarding age of diagnosis, severity & treatment. If relative include the relationship to your child (example mom, dad, grandma, etc)** |
|---|---|---|---|
| Congenital defects/genetic disorders | | | |
| *Infectious*: recurrent ear infections, abscess, immune deficiency, HIV/AIDS, tuberculosis, hepatitis | | | |
| *Pulmonary*:asthma, cystic fibrosis, pneumonia | | | |
| *Gastrointestinal*: reflux(heartburn), inflammatory bowel disease, irritable bowel syndrome, celiac disease | | | |
| *Cardiovascular*: High blood pressure, high cholesterol, angina, heart attack, stroke, aneurysm, sudden death | | | |
| Hearing impairment or deafness | | | |
| *Visual problems:* blindness, “lazy eye” | | | |

| | | | |
|---|---|---|---|
| *Learning, behavior, mental health, &neurological problems:*<br>• Autism, Asperger disorder<br>• Inattention, Hyperactivity<br>• Language delays<br>• Headaches, seizures<br>• OCD behaviors<br>• Learning disability, Special education, mental retardation, down's syndrome | | | |
| *Hematologic:* anemia, excessive bleeding, excessive blood clots, sickle cell trait/ disease | | | |
| *Endocrine:* Diabetes (specify type I or II), thyroid conditions, polycystic ovarian disease(PCOS), or other hormone disorder | | | |
| *Renal:* Recurrent urinary tract infections, kidney infections, kidney reflux, polycystic kidney disease, dialysis | | | |
| *Rheumatologic:* Lupus, rheumatoid arthritis, other | | | |
| *Psychiatric:* Depression, anxiety, bipolar disorder, substance abuse, schizophrenia | | | |
| *Cancer* | | | |

| |
|---|
| Other Medical Illnesses: |

**III. Child's Birth History: (Please respond to all items)**

| | |
|---|---|
| Were any chemical substances consumed during pregnancy? ☐ cigarettes ☐ alcohol ☐ marijuana ☐ other_____ | |
| Were there any concerns during pregnancy, labor, and delivery? If yes, please explain: | |
| How was your child delivered? ☐ vaginal birth ☐ cesarean section | How many weeks gestation was your child at birth? |
| How many days after birth was infant released from the hospital? _____ | Infant's weight at birth:_____ |

**IV. Education History**

| | | | |
|---|---|---|---|
| Early Intervention? (age 0-3) If yes, check all that apply and indicate how often (i.e. 1 hour/weekly) | | | |
| ☐ Speech/language therapy<br>How often:_____ | ☐ Occupational therapy<br>How often:_____ | ☐ Consultation with "interventionist"<br>How often:_____ | ☐ Structured play/social group<br>How often:_____ |
| Please describe any other types of therapies during ages 0-3: | | | |

Was a multi-factored evaluation completed at age 3? ☐ Yes ☐ No
If yes, by which school district: _____

| |
|---|
| Preschool (year 1): ? special education ? inclusion setting ? private community school |
| Did staff relate any concerns to you about your child's development or classroom behavior? If so, please describe: |
| Preschool (year 2): ? special education ? inclusion setting ? private community school |
| Did staff relate any concerns to you about your child's development or classroom behavior? If so, please describe: |
| Preschool (year 3): ? special education ? inclusion setting ? private community school |
| Did staff relate any concerns to you about your child's development or classroom behavior? If so, please describe: |

| |
|---|
| Between ages 3 and kindergarten did your child receive any therapies? If so please describe: |

| **Elementary School Years** | | | |
|---|---|---|---|
| Kindergarten: | ? special education classroom | ? inclusion setting | ? regular education |
| 1st grade: | ? special education classroom | ? inclusion setting | ? regular education |
| 2nd grade: | ? special education classroom | ? inclusion setting | ? regular education |
| 3rd grade: | ? special education classroom | ? inclusion setting | ? regular education |
| 4th grade: | ? special education classroom | ? inclusion setting | ? regular education |
| 5th grade: | ? special education classroom | ? inclusion setting | ? regular education |
| 6th grade: | ? special education classroom | ? inclusion setting | ? regular education |
| Have teachers reported any concerns regarding academic and/or behavioral difficulties? If yes, please explain: | | | |
| **Middle School Years:**<br>Have teachers reported any concerns regarding academic and/or behavioral difficulties? If yes, please explain: | | | |
| **High School Years:**<br>Have teachers reported any concerns regarding academic and/or behavioral difficulties? If yes, please explain: | | | |

## V. Medical Problems/History

| |
|---|
| Is this child presently on medication? (if you have a list, please attach)<br>Name of medication Prescribed for: (Helpful, Not Helpful) Outcome Unusual Reaction<br><br>1.<br>2.<br>3. |
| Has this child previously been on medication?<br>Name of medication Prescribed for: (Helpful, Not Helpful) Outcome Unusual Reaction<br><br>1.<br>2.<br>3. |
| Please indicate any allergies (include drug, food, etc): What problems did the allergy cause?<br>1.<br>2. |
| Please list any previous surgeries: Age Diagnosis |
| Please list any alternative therapies, home remedies, dietary supplement: |
| For girls: age at first menstrual period or none: Regular? ☐ Yes ☐ No |

**<u>ONLY</u> if your child is here for an EEG evaluation please complete the following sections:**

Has your child has any of the following? If yes, please explain.

| **Problem** | **If yes, please check** | **Please explain:** |
|---|---|---|
| Staring spells | | |
| Seizures (with or w/o fever) | | |
| Head trauma | | |
| Headaches | | |
| Speech problems | | |
| Tics or repeated movements | | |
| Weight loss | | |
| Rapid weight gain | | |
| Trouble with appetite | | |

| | | |
|---|---|---|
| Unexplained fevers | | |
| Vision problems | | |
| Hearing problems | | |
| Heart problems | | |
| Hay fever/asthma | | |
| Lung problems | | |
| Diarrhea or constipation | | |
| Stomach or bowel problem | | |
| Urinary tract infection | | |
| Kidney problems | | |
| Broken bones or joint problems | | |
| Skin problems | | |
| Birth marks | | |
| Endocrine problems | | |
| Anemia (low blood) | | |
| Immunologic problems | | |
| Immunization reactions | | |
| Other? | | |

**Evaluation History:**
Has your child participated in any assessments/evaluations or received treatment through a private professional, school or other agency? If yes, please list in order:

| | | | |
|---|---|---|---|
| Name of Professional/Organization: | Purpose:<br><br>Diagnosis: | Report available? ☐ yes ☐ no | Date of testing: |
| Name of Professional/ Organization: | Purpose:<br><br>Diagnosis: | Report available? ☐ yes ☐no | Date of testing: |
| Name of Professional/ Organization: | Purpose:<br><br>Diagnosis: | Report available? ☐ yes ☐ no | Date of testing: |
| Name of Professional/ Organization: | Purpose:<br><br>Diagnosis: | Report available? ☐yes ☐ no | Date of testing: |
| Name of Professional/ Organization: | Purpose:<br><br>Diagnosis: | Report available? ☐ yes ☐ no | Date of testing: |

Has your child had any EEG's, CT scans, or MRI scans?

EEG ☐ Yes ☐ No If yes, when: _____ where: _____ outcome: _____

CT ☐ Yes ☐ No If yes, when: _____ where: _____ outcome: _____

MRI ☐ Yes ☐ No If yes, when: _____ where: _____ outcome: _____