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Child History / Information

Child's Name:____ Date: _________________

Address (Street, City, State, Zip): ____

____

Parent's or guardian phone: (H) _______________________ (W) ________________________

Age _____ Birthdate _________________ Religion _______________________________

Sex _____ Ethnic or racial background ____

Grade and school ____

Special Placement (if any) ____

Hand child uses for writing or drawing: Right ____ Left ____ Switches between them ____

Primary language _______________________ Secondary language ________________________

Medical diagnosis (if any) (1) ____

(2) ____

(3) ____

(4) ____

Who referred the child? ____

Were you referred for an assessment or for therapy/intervention? ___________________________

Briefly describe the problem(s)

(1) ____

(2) ____

(3) ____

(4) ____

What specific questions would you like answered by this evaluation?

(1) ____

(2) ____

(3) ____

(4) ____

THIS FORM HAS BEEN COMPLETED BY:

Name ___________________________________ Relationship to child ____________________

Address ____

Phone (H) ______________________________ (W) _____________________________________

SYMPTOM SURVEY

All children exhibit, to some degree, the behaviors listed below. Check those that you believe your child exhibits to a greater degree compared to other children of the same age. Then, check if this is a NEW symptom (within the past year OR after the injury/illness) or an OLD symptom (over one year OR before the injury or illness). Add any comments next to the item.

1) PROBLEM SOLVING

√	New	Old	
❑	___	___	Difficulty figuring out how to do new things
❑	___	___	Difficulty making decisions
❑	___	___	Difficulty planning ahead
❑	___	___	Difficulty solving problems a younger child can do
❑	___	___	Disorganized in his/her approach to problems
❑	___	___	Difficulty understanding explanations
❑	___	___	Difficulty doing things in the right order (sequencing)
❑	___	___	Difficulty verbally describing the steps involved in doing something
❑	___	___	Difficulty completing an activity in a reasonable period of time
❑	___	___	Difficulty changing a plan or activity when necessary
❑	___	___	Is slow to learn new things
❑	___	___	Difficulty switching from one activity to another activity
❑	___	___	Easily frustrated
❑	___	___	Other problem solving difficulties ______________________________

2) SPEECH, LANGUAGE, AND MATH SKILLS

√	New	Old	
❑	___	___	Difficulty speaking clearly
❑	___	___	Difficulty finding the right word to say
❑	___	___	Not talking
❑	___	___	Rambles on and on without saying much
❑	___	___	Jumps from topic to topic
❑	___	___	Odd or unusual language or vocal sounds
❑	___	___	Difficulty understanding what others are saying
❑	___	___	Difficulty understanding what h/she is reading
❑	___	___	Difficulty writing letters or words
❑	___	___	Difficulty reading letters or words
❑	___	___	Difficulty with spelling
❑	___	___	Difficulty with math
❑	___	___	Other speech, language, or math problems: ________________________

3) SPATIAL SKILLS

√	New	Old	
❑	___	___	Confusion telling right from left
❑	___	___	Has difficulty with puzzles, Legos, blocks, or similar games
❑	___	___	Problems drawing or copying
❑	___	___	Difficulty dressing (not due to physical disability)
❑	___	___	Problems finding his/her way around places he/she has been to before
❑	___	___	Difficulty recognizing objects
❑	___	___	Seems unable to recognize facial or body expressions of disapproval or emotions
❑	___	___	Gets lost easily
❑	___	___	Other spatial problems: ____________________________________

4) AWARENESS AND CONCENTRATION

√	New	Old	
❑	___	___	Easily distracted by: Sounds ___ Sights ___ Physical Sensations ___
❑	___	___	Mind appears to go blank at times
❑	___	___	Loses train of thought
❑	___	___	Difficulty concentrating on what others ay, but can sit in front of a TV for long periods
❑	___	___	Attention starts out OK but can't keep it up
❑	___	___	Other attention or concentration problems: ______________________________

5) MEMORY

√	New	Old	
❑	___	___	Forgets where he/she leaves things
❑	___	___	Forgets things that happened recently (e.g., last meal)
❑	___	___	Forgets things that happened days/weeks ago
❑	___	___	Forgets what he/she is supposed to be doing
❑	___	___	Forgets names more than most people do
❑	___	___	Forgets school assignments
❑	___	___	Forgets instructions
❑	___	___	Other memory problems ______________________________

6) MOTOR AND COORDINATION

Check the side this occurs on:

√	New	Old		Right	Left	Both Sides
❑	___	___	Poor fine motor skills (e.g., using a pencil or crayon)	___	___	___
❑	___	___	Clumsy	___	___	___
❑	___	___	Weakness	___	___	___
❑	___	___	Tremor	___	___	___
❑	___	___	Muscles are tight or spastic	___	___	___
❑	___	___	Odd movements (posturing, peculiar hand movements, etc.)	___	___	___
❑	___	___	Drops things more than most children			
❑	___	___	Has an unusual walk			
❑	___	___	Problems running			
❑	___	___	Balance problems			
❑	___	___	Other motor or coordination problems: ______________________________			

7) SENSORY

Check the side this occurs on:

√	New	Old		Right	Left	Both Sides
❑	___	___	Needs to squint or move closer to page to read	___	___	___
❑	___	___	Problems seeing objects	___	___	___
❑	___	___	Loss of feeling			
❑	___	___	Problems hearing sounds			
❑	___	___	Difficulty telling hot from cold			
❑	___	___	Difficulty smelling odors			
❑	___	___	Difficulty tasting food			
❑	___	___	Overly sensitive to: Touch ___ Light ___ Noise ___			

❑ Other sensory problems: ______________________________

8) PHYSICAL

√	New	Old		How often?
❑	___	___	Frequently complains of headaches or nausea	________________
❑	___	___	Has dizzy spells	________________
❑	___	___	Has pains in joints. *Where?* ____	
❑	___	___	Excessive tiredness	
❑	___	___	Frequent urination or drinking	
❑	___	___	Other physical problems: ____	

9) RELATING TO OTHERS

√	New	Old	
❑	___	___	Was not cuddly as a baby
❑	___	___	"In a world of his or her own"
❑	___	___	"Clings" to people
❑	___	___	Is very fearful of strangers
❑	___	___	Has trouble developing and maintaining friendships
❑	___	___	Refers to acquaintances as "friends"
❑	___	___	Is often teased or bullied
❑	___	___	Does not seem to care about what other people think or feel
❑	___	___	Does not seem to understand the point of view of others
❑	___	___	Prefers play with younger children rather than peers
❑	___	___	Plays better with older children or adults rather than peers
❑	___	___	Wants friends but has a poor grasp of the concept of friendship
❑	___	___	Prefers to be alone
❑	___	___	Is aloof or distant
❑	___	___	Has difficulty using eye contact, facial expressions, and gestures to augment verbal communication
❑	___	___	Directs other children during play and is not interested in the ideas or suggestions of others

10) BEHAVIOR

√	New	Old	
❑	___	___	Aggressive
❑	___	___	Attached to things, not people
❑	___	___	Insists on doing things a certain way
❑	___	___	Needs things to happen just as expected
❑	___	___	Bedwetting
❑	___	___	Bizarre behavior
❑	___	___	Bowel movements in underwear
❑	___	___	Dependent
❑	___	___	Depressed
❑	___	___	Eating habits are poor
❑	___	___	Emotional
❑	___	___	Fearful
❑	___	___	Immature
❑	___	___	Has intense interest in a certain topic
❑	___	___	Is overly sensitive to change or disruption of routine
❑	___	___	Has limited flexibility, for example food selection, clothing or certain rituals
❑	___	___	Nervous
❑	___	___	Nightmares, night terrors, sleepwalks
❑	___	___	Quiet
❑	___	___	Resists change
❑	___	___	Risk-taking

❑ ___ ___ Self-mutilates
❑ ___ ___ Self-stimulates
❑ ___ ___ Shy and withdrawn
❑ ___ ___ Sleeping habits are poor
❑ ___ ___ Swears a lot
❑ ___ ___ Unmotivated
❑ ___ ___ Other unusual behavior ____

10a) SPEECH (Pragmatics)

√ New Old
❑ ___ ___ Had slow speech development
❑ ___ ___ Has unusual tone or pitch
❑ ___ ___ Has difficulty understanding speech
❑ ___ ___ Seldom speaks unless prompted
❑ ___ ___ Repeats words or phrases over and over
❑ ___ ___ Repeats questions instead of answering them
❑ ___ ___ Repeats dialog from movies or songs excessively
❑ ___ ___ Has difficulty initiating or sustaining reciprocal conversation
❑ ___ ___ Talks excessively about favorite topics
❑ ___ ___ Has trouble adapting to change in topic during conversation
❑ ___ ___ Often avoids looking at people when spoken to

10b) RESPONSE TO SOUNDS/SPEECH

√ New Old
❑ ___ ___ Often ignores sounds
❑ ___ ___ Is afraid of certain sounds
❑ ___ ___ Often ignores what is said to him or her
❑ ___ ___ Seems to hear distant or soft sounds that most other people don't hear or notice
❑ ___ ___ really likes certain sounds (music, motors, etc.)
❑ ___ ___ has unpredictable response to sounds (e.g. sometimes reacts, sometimes doesn't)
❑ ___ ___ has trouble with non-literal language, such as idioms (e.g. "Let's hit the road")

10C) VISUAL RESPONSE

√ New Old
❑ ___ ___ Stares vacantly around the room
❑ ___ ___ Likes to look at self in mirror
❑ ___ ___ Likes to look at self in mirror
❑ ___ ___ Stares at parts of his or her body (e.g. hands)
❑ ___ ___ Seems to look at things out of the corner of his or her eye and not looking directly at them
❑ ___ ___ Plays with lights by turning them on and off repeatedly
❑ ___ ___ Is very interested in small parts of objects
❑ ___ ___ Has difficulty initiating or sustaining reciprocal conversation

Below, circle the number that best describes your child's behavior and has been present for at least the **past 6 months**. 0 = Never or very rarely, 1 = Sometimes, 2 = Often. 3 = Very Often or almost Always

Behavior				
Fails to give close attention to details or makes careless mistakes in schoolwork (i.e., overlooks or misses details, work is inaccurate)	0	1	2	3
Has difficulty sustaining attention in tasks or play activities (has difficulty remaining focused during conversations or lengthy reading)	0	1	2	3
Does not seem to listen when spoken to directly	0	1	2	3
Does not follow through on instructions and fails to finish school work or chores (e.g., starts tasks but quickly loses focus or is easily sidetracked)	0	1	2	3
Has difficulty organizing tasks and activities (messy/disorganized work, poor time management)	0	1	2	3
Avoids tasks (e.g., schoolwork, homework) that require mental effort	0	1	2	3
Loses things necessary for tasks or activities (school materials, pencils, etc)	0	1	2	3
Is easily distracted by extraneous stimuli	0	1	2	3
Is forgetful in daily activities	0	1	2	3
Fidgets with or taps hands or feet or squirms in seat	0	1	2	3
Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
Runs about or climbs excessively in situations in which it is inappropriate	0	1	2	3
Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
Is "on the go" or acts as if "driven by a motor" (Unable to be or uncomfortable being still for extended time in classroom, restaurants, meals)	0	1	2	3
Talks excessively	0	1	2	3
Blurts out answers before questions have been completed	0	1	2	3
Has difficulty awaiting turn	0	1	2	3
Interrupts or intrudes on others	0	1	2	3
Loses temper	0	1	2	3
Argues with adults	0	1	2	3
Actively defies or refuses to comply with adults' requests or rules	0	1	2	3
Deliberately annoys people	0	1	2	3
Blames others for his/her mistakes or misbehavior	0	1	2	3
Is touchy or easily annoyed by others	0	1	2	3
Is angry and resentful	0	1	2	3
Is spiteful or vindictive	0	1	2	3

Does your child's teacher describe any of the following as significant classroom problems?

___Easily distracted
___Frequently gets up and walks around classroom
___Shouts out
___Doesn't cooperate well in group activities
___Difficulty shifting from one activity to another
___Doesn't respect the rights of others
___Doesn't sit still in his/her seat
___Doesn't want to be called on
___Won't wait his/her turn
___Difficulty sustaining attention
___Typically does better in one to one setting

Additionally, has the child engaged in any of the following over the last 12 months

_______ Steals things without people knowing on several occasions
_______ Often runs away from his parents' home and stays away overnight
_______ Easily lies to others
_______ Fire setting
_______ Doesn't go to school
_______ Breaks into other people's property
_______ Destroys other people's property in some manner other than by fire
_______ Is cruel to animals
_______ Has forcible sexual relations with others
_______ When fighting, has used a weapon on more than one occasion
_______ Starts fights with others
_______ Will steal directly from people
_______ Is cruel to other people

10) Overall, the child's symptoms have developed: _____ Slowly _____ Quickly

11) The symptoms occur: _____ Occasionally _____ Often

12) Over the past 6 months the symptoms have: _____ Stayed about the same _____ Worsened

PREGNANCY

13) Mother's age at birth: _____ Father's age at birth: _____

14) **Before** the pregnancy, what medications (prescribed or over-the-counter) did the mother take?
List all medications used: ______________________________

15) **While** pregnant, what medications (prescribed or over-the-counter) did the mother take?
List all medications used: ______________________________

16) How often did the mother see her doctor during the pregnancy?
Regularly (as scheduled by the doctor) ____ Rarely ___ Not at all ____

17) During the pregnancy, which of the following did the mother use?

		Amount and Daily Frequency
____	Alcohol	______________________
____	Caffeine (coffee, colas, etc.)	______________________
____	Marijuana	______________________
____	Recreational drugs (cocaine, heroin, etc.)	______________________
____	Tobacco	______________________

18) During pregnancy, the mothers diet was: Good ___ Poor ____
If poor, explain: ______________________________

19) The mother's general physical health during the pregnancy was: Good ____ Poor ____
If poor, explain: ______________________________

20) About how much weight did the mother gain while she was pregnant? ______ lbs.

21) During this pregnancy, check all the mother had:
_____ Accident
_____ Anemia
_____ Bleeding (severe or frequent spotting)

_____ Diabetes
_____ High blood pressure
_____ Illnesses or infections
_____ Preeclampsia, eclampsia, or toxemia
_____ Psychological problems
_____ Surgery
_____ Vomiting (severe or frequent)

22) How many pregnancies did the mother have prior to this one?
Number of live births: _____
Number of miscarriages: _____
Number of abortions _____

BIRTH

23) Was the child born:
Early ____ How early? _____ weeks
On time ____ (38-42 weeks)
Late ____ How late? _____ weeks

24) How much did the baby weight at birth? _____ lbs. _____ oz. OR _____ gms

25) How long did the labor last? ____

26) The labor was: Easy _____ Moderately difficulty _____ Very difficult _____

27) What type of medication was the mother given to help with delivery? None _____
Demerol ___ Gas ___ Regional nerve (spinal) block ___ Tranquilizer ___ Epidural ____

28) Were forceps used during delivery? Yes ____ No ____

29) Was the baby born:
Head first ____ Transverse (crosswise) ____ Posterior first ____
Breech birth ____ Caesarean section ____ Vacuum extraction ____
Other: ____

30) Did the baby experience any of these problems:
Fetal distress _____ Low placenta (Placenta previa) _____ Prolapsed cord _____
Premature separation of the placenta (Abruptio placenta) _____

31) Describe any other special problems the mother or child had during delivery:
____
____

32) At birth, did the baby:
Have difficulty breathing? Yes ___ No ___
Fail to cry? Yes ___ No ___
Appear Inactive? Yes ___ No ___

33) List the baby's Apgar scores: 1st ___ 2nd ___

34) If the father or mother noticed anything unusual when they first saw the baby, describe:
____
____

35) If the baby was born with any problems (congenital defects, large or small head, blue baby, bleeding in brain, etc.), describe: ____

____

36) Describe any special problems that the baby had in the first few days or weeks following birth:

____

____

37) Describe any special care, treatment, or equipment the child was given after birth:

____

38) How long did the baby stay in the hospital? ______________________________________

DEVELOPMENTAL HISTORY

39) For each area, indicate the child's development by circling one description. The "Average" period is only a rough idea of what is average since every developmental milestone actually involves a range of several months (e.g., walking occurs approximately 9-18 months of age). Circle "Early" or "Late" only if you are sure the child's development was different from that of most other children.

GROSS MOTOR SKILLS			
Crawled	Early	Average (6-9 months)	Late
Walked alone (2-3 steps)	Early	Average (9-18 months)	Late
Pedals a tricycle	Early	Average (32-26 months)	Late
LANGUAGE			
Followed simple commands	Early	Average (12-18 months)	Late
Used single-word	Early	Average (12-24 months)	Late
Said phrases	Early	Average (24-36 months)	Late
Names primary colors	Early	Average (36 to 48 months)	Late
ADAPTIVE			
Toilet trained	Early	Average (13-36 months)	Late
Feeds self with spoon	Early	Average (21-24 months)	Late
Takes off open shirt/coat	Early	Average (18-24 months)	Late

40) List any other significant developmental problems:

____

____

41) Overall, the child's development was:
Early ____ Average ____ Late ____

42) As an infant or toddler, did the child have poor muscle control (i.e., weakness) of the:
Neck ____ Trunk ____ Legs ____ Arms ____

43) As an infant or toddler, did the child's muscles seem to be unusually tight or stiff?
Yes ___ No ____ If yes, describe: ______________________________________

44) Toilet training was: Easy ____ Difficult ____

45) As an infant, to a significant degree, were any of the following present during the first two years of life?

Did not enjoy cuddling	____	Poor eye contact	____
Was not calmed by being held or stroked	____	Twitching	____
Difficult to comfort	____	Withdrawn behavior	____
Colic	____	Destructive behavior	____
Excessive restlessness	____	Unable to separate from parent	____
Poor sleep	____	Eating problems	____
Head banging	____	Excessive crying	____
Difficult nursing	____		

46) Please rate the following behaviors as you child appeared during infancy and toddlerhood:

Activity Level – How active has your child been from an early age? ____________________________

____

Distractibility – How well did your child pay attention? ____

____

Adaptability – How well did your child deal with transition and change? __________________________

____

Approach/Withdrawal – How well did your child respond to new things (i.e. people and places)?

____

Mood – What was your child's basic mood? ____

____

Regularity – How predictable was your child in patterns of sleep, appetite, routines, etc.? __________

____

Adaptive Skills

Feeds self:	No	Yes
Dresses self:	No	Yes
Bathes self:	No	Yes
Helps with household chores:	No	Yes
Knows phone number and address:	No	Yes
Says "please" and "thank you":	No	Yes
Tells time accurately:	No	Yes

Has the child ever lost skills, which at one time he or she was able to perform? No Yes

If yes, please explain: ____

When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?

Time out	Loss of allowance / privileges	Physical punishment	Yelling
Ignoring	Grounding	Other, describe______________________________	

Who is mainly in charge of discipline? ______________________

What do you find most difficult about raising your child? _______________________________________

____

HEALTH HISTORY

47) Did the child have a good appetite as a baby? Yes ___ No ___

48) Did the child fail to gain weight steadily as a baby? Yes ___ No ___

49) List the baby's illnesses or physical problems during the first year:

____

50) Has the child had a temperature of 104°F (40°C) or higher for more than a few hours?

Yes ___ No ___ If yes, what age(s)? ____________ and how long did it last? _______________

51) Has the child ever been hit hard on the head or suffered a head injury? Yes ___ No ___
If yes, what age(s)? _______________ Did the child lose consciousness? Yes ___ No ___
How did it happen? ____
What problems did the child have (physical or mental) afterwards?
____
____

52) Has the child been diagnoses with seizures or epilepsy?
If yes, which type? Partial seizure ___ Generalized seizure ___ Unclassified type ___
If medication is used, what medication(s)? ______________________________
Has the child ever had a bad reaction to this medicine? Yes ___ No ___
If yes, describe: ____
Did the child ever have a seizure due to a fever or unknown cause? Yes ___ No ___
If yes, describe (age, nature of seizure): ______________________________

53) Was the child ever in the hospital for an accident, injury, or operation? Yes ___ No ___
If yes, what age(s)? __________ What happened? ______________________________
____
____

54) Has the child ever swallowed any poison, non-food, or drug accidentally? Yes ___ No ___
If yes, what age(s)? __________ What happened? ______________________________

55) Did the child have frequent ear infections? Yes ___ No ___
If yes, what age(s)? __________ How often and severe? ______________________________
What treatment was provided? ____

56) Please check all the following diseases or conditions the child has ever had:

____	Allergies	___	Cerebral Palsy	___	Jaundice	___	Mumps
____	Anemia	___	Chicken Pox	___	Kidney Disorder	___	Oxygen deprivation
____	Asthma	___	Colds (excessive)	___	Leukemia	___	Pneumonia
____	Bleeding disorder	___	Diabetes	___	Liver disorder	___	Rheumatic fever
____	Blood disorder	___	Encephalitis	___	Lung Disorder	___	Scarlet fever
____	Brain disorder	___	Enzyme deficiency	___	Measles	___	Tuberculosis
____	Broken bones	___	Genetic disorder	___	Meningitis	___	Venereal disease
____	Cancer	___	Heart disorder	___	Metabolic disorder	___	Whooping cough
____	Eye problems	___	Tics (eye blinking, sniffing, and repetitive movement)				
____	Other problems						

____

57) As the child has been growing up, he/she has been sick:
Much of the time ____ An average amount ____ Not much at all ____

58) List all the medications the child takes now:

Medication	Dosage	How often?	What for?
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

59) Does the child?
Wear glasses? Yes ___ No ___ (Farsighted ___ Nearsighted ___ Other ___)
Use a hearing aid? Yes ___ No ___

60) Within the past year has the child had: **RESULTS**

A vision test? Yes ___ No ____

A hearing test? Yes ___ No ____

61) What is the child's: Height: _____ ft. _____ in. Weight: _____ lbs.

62) When was the child's last medical checkup?

____

63) What therapies have been provided to the child? _____ No therapies

- _____ Occupational therapy
- _____ Physical therapy
- _____ Psychological therapy, counseling, or cognitive rehabilitation
- _____ Speech therapy
- _____ Other therapy

____

FAMILY HISTORY

64) The child lives with:

___ Biological parent(s) only ___ Relatives ___ Foster parents

___ Biological parent and other ___ Adoptive parents ___ Institutional care

___ Other placement

Please list all the people currently living in the home with the child and their relation to the child (include family and nonfamily members)

____

____

____

65) The family's income is:

under $10,000 ___ $10,000-29,999 ___ $30,000-50,000 ___ over $50,000 ___

66) What is the name of the child's biological mother? ____

a. Is she living? Yes ___ No ___ If deceased, explain: ______________________

b. Her age? ________

c. What is her level of education? ____

d. Her occupation? ____

If mother works outside the home, how may hours and what days ___________________________

e. Does she live in the same house as the child? Yes ____ No ____

f. How often does she see the child? ____

g. How involved is the mother in the child's upbringing? Very ___ Somewhat ___Not at all ___

h. During school, did the mother have:

Learning problems ____

Attention problems ____

Behavior problems ____

Medical problems ____

i. What are the mother's hobbies? ____

j. What is mother's primary language __________________ Secondary language ________________

67) What is the name of the child's biological father? ______________________________________

a. Is he living? Yes ___No ___ If deceased, explain: _________________________________

b. His age? ________

c. What is his level of education? ____

d. His occupation? ____

If father works outside the home, how may hours and what days ____________________________

e. Does he live in the same house as the child? Yes ____ No ____
f. How often does he see the child? ____
g. How involved is the father in the child's upbringing? Very ___ Somewhat ___ Not at all ___
h. During school, did the father have:
Learning problems ____
Attention problems ____
Behavior problems ____
Medical problems ____
i. What are the father's hobbies? ____
j. What is father's primary language __________________ Secondary language ________________

68) Please list the names, ages, and grade (or job) of the child's brothers and sisters:

Name	Age	Grade or job	Medical, Social, School Problems

69) Has anyone in the child's biological family (including parents, grandparents, siblings, aunts, and uncles) ever had any of the following?

		Which relative?	Describe the problem briefly
____	Brain disease		
____	Developmental Delay		
____	Epilepsy or seizures		
____	Learning disability		
____	Mental retardation		
____	Neurologic disease		
____	Psychological problems		
____	Reading/spelling difficulties		
____	Speech/language problems		

70) Which of the child's biological relatives are left-handed? No one _____
Mother _____ Father _____ Sibling(s) _____ Grandparents _____

71) What languages are spoken in the home? (List in order of most frequent first)
(1) ____________________________________ (2) ____

72) How is the child disciplined? ____
____
Is the discipline effective? ____

73) List the child's usual recreational activities and hobbies: ______________________________________
____
____

74) Have there been any major family stresses or changes in the past year (e.g., moving with change of school, divorce, significant illness, etc.)? Yes ___ No ___
If yes, explain: ____
____
____

How much stress has these changes caused the child? (circle one)

None   Mild   Moderate   Severe

75) Does the child attend day care outside the home or does someone come into the home to provide the service? ______________________________

Does day care provide any type of formal program of play, developmental, or academic activites?

____

____

PEER RELATIOHSIPS

76) Does your child seek friendships with peers? ______________________________

____

77) Is your child sought by peers for friendship?______________________________

____

78) Does your child play with children primarily his or her own age ? ______________________________

Younger? ______________________________ Older? ______________________________

79) Describe any problems your child may have with peers ______________________________

____

SCHOOL HISTORY

80) The child's present school is: Name ______________________________

Address ______________________________

Phone ______________________________ Contact person ______________________________

81) Was the child ever held back to repeat a grade? Yes ___ No ___

If yes, which grade? ________ Why? ______________________________

____

82) Has the child ever been in a special class or provided with special services (e.g., RSP, Self-contained day class, learning or language disability class, etc.) Yes ___ No ___

If yes, describe the special class ______________________________

____

Is the child in this class or receiving special services now? Yes ___ No ___

If yes, describe the present class placement ______________________________

____

83) Does the child like school? Most of the time ___ Sometimes ___ Almost never ___

84) Does the child:

Have problems with other children in class? Yes ___ No ___

Have problems making friends in school? Yes ___ No ___

Have problems getting along with teachers? Yes ___ No ___

Tend to get sick in the morning before school? Yes ___ No ___

85) Describe the teacher's concerns about the child's schoolwork or behavior:

____

____

86) What kind of grades has the child received in the past year?

A's & B's ____ B's & C's ____ C's & D's ____ D's & F's ____

Or

Outstanding ___ Good ____ Satisfactory ___ Improvement needed ___ Unsatisfactory ___

Or
Other grading system ____
Are these grades a change from previous years? Yes ___ No ___
If yes, describe ____
____

87) In which subject(s) does the child do best? ___________________________________
____

88) Which subject(s) are the most difficult? _____________________________________
____

89) In the past year, how much school has the child missed due to illness or injury?
Less than 2 weeks ___ 2-4 weeks ___ 5-8 weeks ___ Over 8 weeks ___
Briefly describe the reasons if the child has missed a lot of school:
____
____

90) Does the child seem to have a "school phobia?" Yes ___ No ___
If yes, explain: ____

91) Do you consider your child to understand directions and situations as well as other children his or her age? ____
____

92) How would you rate your child's overall intelligence compared to other children?
Below average _____ Above average _____ Average _____

PREVIOUS EVALUATIONS
93) Which of these tests or procedures has recently has been done? Note if normal or abnormal

	Evaluation	**Normal**	**Abnormal**	**Date**
___	Blood work	______	_________	________________________
___	Family physician or pediatrician office visit	______	_________	________________________
___	Hearing testing	______	_________	________________________
___	Lead level check	______	_________	________________________
___	Lumbar puncture or spinal tap	______	_________	________________________
___	Neurological examination or testing (CT scan, EEG)	______	_________	________________________
___	Psychological or Neuropsychological testing	______	_________	________________________
___	School testing	______	_________	________________________
___	Speech & Language testing	______	_________	________________________
___	Vision testing	______	_________	________________________
___	X-rays	______	_________	________________________
___	Other tests:			
	____________________________	______	_________	________________________
	____________________________	______	_________	________________________

94) What are the names of the physician, psychologist, school authority, or other professionals who are most familiar with the child's problems?

Name ____________________________________
Address __________________________________
____
Phone ____________________________________
Profession ________________________________

Name ________________________________
Address ______________________________
____
Phone ________________________________
Profession ____________________________

Please Note: If your child has seen a psychologist at any time in the last year for testing or treatment, please be sure to advise the doctor.

ADDITIONAL COMMENTS: Please note below any further information you feel may be helpful in the evaluation of your child

____
____
____
____
____
____
____

____ ____________________
Parent or Guardian's Signature Date

THANK YOU FOR TAKING THE TIME TO CAREFULLY COMPLETE THIS QUESTIONNAIRE.