Please help us to understand your child better by completing the following form.

Child's Name: ___________________________________

Date of Birth: ____________ **Age:** ____________

City/County: _______________________/__________________________

Name/relation of person filling out form: _____________________________

Referral source: ____

Reason for evaluation:

When and why did you first become concerned about your child?

What would you like to learn from the evaluation?

Family History
Please list the names, ages, and occupations, of all persons living in the home (include parents, siblings, and relatives)

Name	Age	Relationship	Occupation
1.			
2.			
3.			
4.			
5.			

Family History- Has anyone in the family or extended family of either parent had any medical, neurological, developmental, learning behavioral or psychiatric conditions? Please check the condition and list the relationship (mother/father/sibling/grandparent/aunt/uncle/cousin):

Yes	Condition	Family Member(s) (Maternal/Paternal)
______	Developmental or Cognitive Delay	
______	Speech or Communication Disorder	
______	Intellectual Disability	
______	ADHD/ADD	
______	Learning Difficulties (LD)	
______	Autism Spectrum Disorder/AspergerSyndrome	
______	Anxiety Disorder	
______	Depression	
______	Bipolar Disorder/Manic-Depression	
______	Schizophrenia or Other Psychosis	
______	Alcohol/Substance Abuse	
______	Suicide Attempts/Suicide	
______	Seizure Disorder	
______	Genetic Disorder (Down Syndrome, Fragile X, etc.)	
______	Cardiovascular	
______	Endocrine (Thyroid, Diabetes, Gestational Diabetes, etc.)	
______	Auto-Immune (Lupus, Diabetes, MS, RA, etc.)	

_____ Gastrointestinal ______________________________

_____ Genito-Urinary ______________________________

_____ Pulmonary ______________________________

_____ Cancer ______________________________

_____ Other (Please provide details.) ______________________________

Clinical Notes:

Pregnancy

Prenatal Care: Routine: _____ High Risk: _____ Number of pregnancies: _________

Any difficulties conceiving or maintaining pregnancies? Yes _____ No ________

If “yes”, please provide details: ______________________________

Any complications during this pregnancy? Yes _____ No ______

If “yes”, please provide details: ______________________________

Prescription medication(s) during pregnancy? Yes ______ No _______

If “yes”, please provide details: ______________________________

Any use of alcohol or other substances? Yes ______ No _______

If “yes”, please provide details: ______________________________

Illnesses or infections? Yes ______ No _______

If “yes”, please provide details: ______________________________

Birth History

Delivery: Vaginal: _____ C-Section: ______ Reason for C-Section? Breech: ________

Fetal Distress: _________ Failure for labor to progress: _________ Other: _________

Please provide details: ____

____

Gestational Age: ________ Birth Weight: _________ Length: ____________

Were there any complications during this delivery? Yes ______ No ________

If “yes”, please provide details: ____
Complications/Medical Conditions/Treatments after birth/during neonatal period?

____

____

Length of stay in hospital: ___________________________

Developmental History:

Describe your child’s temperament as an infant (check all that apply):

Contented/Happy: _______ Alert: _____ Interactive: _____ Passive: _____ Colicky: _____

Reflux: _____ Irritable: _______ Fussy: _______ Cried excessively: _____ Slept well: _______

Did not sleep well:_____ Breast fed: _______ Bottle fed: _______

Liked being held/cuddled: _______ Resisted being held/cuddled: _______

Excessive desire to be held/rocked/bounced: _______ Other: ______________________________

Any remarkable/unusual behaviors/habits? Yes _____ No _____

If “yes”, please provide details: ____

____

Did your child smile as a young infant (3+ months)? Yes ____ No ______

Make eye contact?: Yes ____ No _____

At what age did your child:

Sit:________ Crawl:________ Walk:_____________

Did your child babble prior to speaking? Yes____ No____

Speech Progress: Advanced: ____ Typical: ____ Delayed: ____ Significantly Delayed:___

Did your child have any feeding difficulties **in infancy** (check all that apply):

Difficulty latching on: _______ Difficulty coordinating breath/suck/swallow: _______

Reflux/frequent spit ups: _______ Other: ______ Please provide details:

____

____

____

Clinical Notes:

Current Development

Motor Skills:

Gross Motor - Any **difficulties** noted in your child's gross motor skills (check all that apply)?

Walking: _____ Running: _____ Jumping: _____ Climbing: _____ Balance: _____

Bike riding: _____ Kicking balls: _____ Throwing balls: _____ Catching balls: _____

Unusual gait when walking or running: ______ Walking/running on toes: _____

Difficulty with motor coordination: _____ Frequent stumbles/falls: ______

Fine Motor – Any **difficulties** noted in your child's fine motor skills (check all that apply?)

Eating with utensils: _________ Holding writing instruments: ________

Writing/Coloring: _____ Cutting with scissors: _____ Picking up objects: _____

Holding objects: ______ Fastening buttons: ______ snaps: ______ zippers: _______

Tying shoes:_____

Has your child **mastered:** Pincer grasp (picking up small objects with thumb and index finger)?: Yes ______ No______

Does your child hold eating/writing utensils with: Fisted grasp?: _______

Tripod grasp?: _____ Handedness: Right? _____ Left?_____ TBD? _____

____

Clinical Notes:

Cognitive/Learning:

Daycare: ______ Preschool: ______ School: _____ Grade: ______

Name of **present** Daycare/Preschool/School: ________________________________

How many days/week does your child attend daycare/preschool/school? _________

How many hours daily? ________ How many children are in the classroom: _______

How many teachers?: __________ Teaching assistants/Paraprofessionals?: ________

Any history of your child having been asked to leave a daycare, preschool, or private school setting? Yes _____ No _____ If "Yes", please explain:

____

Is your child able to:

- Learn and/or retain information: Yes ____ No _____
- Focus/maintain attention/complete tasks: Yes ___ No ___
- Perform at grade level: Yes ___ No ____
- Follow directions: Yes ____ No ______
- Stay seated and participate in classroom activities: Yes ____ No ____

If "No", please explain: ____

____

Does your child have an IEP (Individualized Education Plan)? Yes ___ No ____

What Services/Accommodations are offered through the IEP (check all that apply)?

Special Needs Preschool: _____ Special Needs Pre-K: ______

Self-Contained classroom: _____ Small group pull-out: ______

Co-taught classroom (1 general education/ 1 special education teacher): ______

Inclusion classroom with paraprofessional support: ______

Speech therapy: _____ Minutes/week: _______

Occupational therapy: _____ Minutes/week: _______

Other services offered: ____

____

Clinical Notes:

Behavior:

Please describe your child's personality, strengths, talents, and interests:

Please describe a "perfect day" for your child:

Please indicate if your child is experiencing any of the following (check all that apply) and if so, please provide details:

Difficulty with transitioning from one activity/location to another: _____

____

Disturbed by changes in routine: _____ Difficulty maintaining attention: ______

____

Impulsive, does not think before acting: ______ Hyperactive, difficulty staying still: _____

____

Generalized anxiety: ______ Specific fears/Phobias: ______ Sadness/Depression: _____

____

Social Anxiety: _____ Obsessive-Compulsive/Rigid behavior patterns: _____

____

Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.): _____

____

Self-injurious behavior: _____ Physical and/or verbal aggression towards others: _____

____

Non-compliant/oppositional/defiant behavior : _____ Problems obeying authority: _____

____

Easily frustrated: _____ Tantrums/meltdowns over seemingly insignificant matters: _____

____

Wetting accidents: _____ Soiling accidents: _____ Sensory over-sensitivities: _____

____

Vocal or motor tics (repeated sounds/involuntary movements): _____

____

Other behavioral difficulties/concerns:

____

____

____

____

Clinical Notes:

Social:

Does your child's behavior affect his or her ability to interact/socialize/communicate?

Yes _____ No _____

If "Yes", please explain:

Please describe your child's relationship with the following:

Parents:

Siblings:

Family members and friends of family:

Same-aged peers:

Teachers (if applicable):

Do you have any concerns regarding the way your child socializes?

Tell us about your child’s friends (older/younger, male/female, outgoing/withdrawn, etc.).

Does your child seem to gravitate towards one age group more than another?

Communication:

Do you have any concerns about your child’s ability to communicate? Yes ___ No ___

Does your child respond to his/her name when called? Yes, always ____

No, never _____ Occasionally _______

Does your child:

Point to objects of desire or interest? Yes ____ No _____

Wave (hello/good-bye)? Yes ____ No _____

Reach out to be picked up? Yes ____ No _____

Does your child speak in/with:

- Complete grammatically correct sentences? Yes ____ No _____
- Complete sentences, not always grammatically correct? Yes ____ No _____
- 2-3 word phrases? Yes _____ No _____
- 1-word utterances? Yes _____ No _____
- Communicative intent? Yes _____ No _____

In what other ways, if any, is your child able to indicate his/her needs?

If your child's language development is delayed, is this a source of frustration/anger for him/her? Yes ____ No _____

Does this frustration/anger often lead to challenging behaviors? Yes ____ No _____

How well is your child able to respond to open-ended questions? (Ex: "What did you do in school today?"):

Clinical Notes

Functional Expression

Please indicate the level of your child's ability to perform the following activities of daily living:

Totally dependent on caregiver = **TD**; Requires Assistance: **RA**; Independent = **I**

Wash and dry hands: _____ Wash and dry face: _____ Brush teeth:_____

Brush or comb hair: _____ Dressing: _____ Undressing: _____ Toileting (bowel): _____

Toileting (bladder): _____

Details/Other:____

____

Sleep

Does your child (check all that apply):

Sleep through the night? ______ How many hours on, average? ________

Sleep in his/her own bed? ______ If not, where/with whom? ________________________

Have difficulty falling asleep? ______ How long does it take, on average? _________

Sleep restlessly? _____ Have nightmares/night terrors? _____ If so, how frequently? _________

Nap?_____ If so, how often/long? _________________

If your child wakes during the night, does s/he (check all that apply): Fall back to sleep independently? _____ Become distressed and start crying? ____

Get into bed with parent(s)? _____ Stay awake for a period of time?_____

If your child stays awake for a period of time, what typically transpires during that time? ________

____

Clinical Notes:

Hearing & Vision

Hearing Screened? Yes ____ No ____ Pass/Fail (circle one)

If Fail, please explain:

Vision Screened? Yes ____ No ____ Pass/Fail (circle one)

If Fail, please explain:

Sensory Integration Challenges (over/under reaction to light, visual stimulation, sounds, tastes, textures, smells, touch, position, environment, et al):

Feeding & Nutrition

Does your child feed him/herself using utensils and/or fingers (when appropriate)?

Yes ____ No _____

Uses fingers only: ______ Fed by caregiver: _____

Describe your child's eating habits:

- Tendency to avoid certain foods? Yes ____ No _____ Which foods? ____________

  ____

- Tendency to avoid certain textures? Yes ____ No _____ If yes,
- Limited variety of foods? Yes _____ No _____
- Reasonable variety of nutritious foods? Yes _____ No _____
- Willing to try new foods? Yes _____ No _____

What foods does he/she prefer?):

Any food allergies or sensitivities? Yes ____ No ____

If yes, please list:

Clinical Notes:

Current Services: (Please indicate provider, how many sessions weekly, and duration of each session.)

SpeechTherapy: ____

OccupationalTherapy: ____

Physical Therapy: ____

Hippo/Aquatic Therapy: ____

Behavioral Therapy (hours/week): ____
Psychotherapy/Counseling: ____

Tutoring: ____

Other: ____

Medical/Surgical History:

A. Does your child have any negative reactions to medications? (Please explain.)

B. Does your child have any seasonal allergies? Other allergies (food, environmental)? Sensitivities (lactose intolerance, rash)? (Please explain.)

C. Are your child's immunizations up to date? Yes _____ No _____

If "No", which immunizations are not up to date? _____________

____

D. Is there a history of any hospitalization(s)? Yes _____ No _____

If "yes" please provide dates and reason for hospitalization(s): _____________

____

____

E. Is there a history of emergency room visit(s)? Yes _____ No _____

If "yes" please provide dates and reason for emergency room visit(s):

____

F. Has your child ever had surgery? Yes _____ No _____

If "yes" please provide dates and reason for surgery:

____

____

G. Has your child ever had any serious injuries? Yes _____ No _____

If "yes" please provide dates and nature of injury: ______________________

____

H. Other Illnesses: Yes _____ No _____
If "yes" please provide dates and illnesses:

____

____

____

Review of Systems: (Please list all specialists, dates, and reason for seeing specialist)

1. **Neurology:** (e.g. Seizures, headache, tics, etc)

2. **Orthopedics:**

3. **Ophthalmology**:

4. **Pulmonary**: (e.g. Asthma or Wheezing)

5. **Gastroenterology:** (e.g. Vomiting & Bowel Movements)

6. **ENT:** (e.g. Ear Infections)

7. **Endocrinology:** (e.g. Thyroid)

8. **Genito/Urinary:**

Puberty:

Female: Yes _____ No _____

If "Yes", approximate date of first menstrual cycle (month/year) : _______________

Frequency/duration of cycle (ex: 28 days/4-5 days): ______________________

Pre-Menstrual Syndrome (PMS)? No _____Yes ______ Severe ______ Moderate

_______ Mild ______ Cramping? No _____ Yes_____ Severe _____

Moderate _____ Mild ______ Well managed (acceptance of monthly cycle, hygiene, discomfort)?

No _____ Yes _____ If "no", please provide details:

____

____

Male: Yes ____ No ____

Concerns:

____

____

9. **Cardiovascular:**

10. **Genetic:**

11. **Other:**

Medications:

Past Medication	**Reason & Date for Starting**	**Reason & Date for Stopping**
1. ____________________	__________________	_______________________________
2. ____________________	___________________	_______________________________
3. ____________________	____________________	_______________________________

Present Medication	**Reason & Date for Starting**	**Current Benefit**
1. ____________________	__________________	_______________________________
2. ____________________	___________________	_______________________________
3. ____________________	____________________	_______________________________

Previous Evaluations/Testing *(Medical, Psychological Evaluations)*

Test	**Date**	**Results**
1. ____________________	__________________	_______________________________
2. ____________________	___________________	_______________________________
3. ____________________	____________________	_______________________________
4. ____________________	_____________________	______________________________

Please attach any previous evaluations your child has received.

We appreciate you taking the time to complete this form for us to review.

Please feel free to provide any additional information below: