

**BACKGROUND INFORMATION:**

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Chronological Age: \_\_\_\_\_

School: \_\_\_\_\_ Grade \_\_\_\_\_

Parent 1 Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

Parent 2 Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

Step-Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status of Parents: Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Other \_\_\_

**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.

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Language(s) spoken if not English: \_\_\_\_\_

List all people now living in your household, then draw a line and list others who have previously 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 or other living arrangements/situations. Describe any deaths in the immediate family. Note any unusual family circumstances.

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Pediatrician: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Permission to speak with pediatrician: Yes \_\_\_\_\_ No \_\_\_\_\_

**PREGNANCY AND BIRTH HISTORY:**

Describe any complications that occurred during pregnancy

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe any complications that occurred during delivery (i.e., prematurity, postmaturity, length of labor, special procedures, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Birth weight? \_\_\_\_\_ How long after birth did you take your baby home? \_\_\_\_\_

**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 independently: \_\_\_\_\_

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.

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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? _____
Cognitive deficits?	Yes _____	No _____	Who? _____
Similar problems to child?	Yes _____	No _____	Who? _____

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

Concussions

Please list dates of any concussions, severity, and treating physician

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How long was your child out of school? When was your child cleared to return to school?

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Does your child experience any ongoing symptoms?

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

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Current medications:

Medicine: \_\_\_\_\_ Dose: \_\_\_ Purpose: \_\_\_\_\_ Prescribed By: \_\_\_\_\_

Medicine: \_\_\_\_\_ Dose: \_\_\_ Purpose: \_\_\_\_\_ Prescribed By: \_\_\_\_\_

Medicine: \_\_\_\_\_ Dose: \_\_\_ Purpose: \_\_\_\_\_ Prescribed By: \_\_\_\_\_

Medicine: \_\_\_\_\_ Dose: \_\_\_ Purpose: \_\_\_\_\_ Prescribed By: \_\_\_\_\_

Has your child's vision been examined? \_\_\_\_\_ Date: \_\_\_\_\_

If so, by whom? \_\_\_\_\_

Results: \_\_\_\_\_

Has your child's hearing been examined? \_\_\_\_\_ Date: \_\_\_\_\_

If so, by whom? \_\_\_\_\_

Results: \_\_\_\_\_

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

Name of Test: \_\_\_\_\_ Date: \_\_\_\_\_

Purpose/Results: \_\_\_\_\_

Previous psychological or neurological evaluations: (List names of providers, addresses, dates, and any pertinent results). **PLEASE PROVIDE A COPY OF THE WRITTEN REPORT.**

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

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Psychotherapy: (List names of therapists, addresses, dates, etc.)

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**SOCIAL-EMOTIONAL/BEHAVIORAL HISTORY:**

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

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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.):

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Current discipline techniques: \_\_\_\_\_

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Who disciplines? \_\_\_\_\_

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Do parents agree on how to discipline? \_\_\_\_\_

How does your child respond to discipline? \_\_\_\_\_

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**SCHOOL HISTORY:**

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

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List current teachers and subjects taught: \_\_\_\_\_

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Describe any learning/behavioral/social difficulties at school:

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

Early Intervention program: \_\_\_\_\_

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TAG/Discovery (Gifted Program): \_\_\_\_\_

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Learning Disability/O.H.I./Student Support Team: \_\_\_\_\_

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Does your child have an IEP or 504 Plan? \_\_\_\_\_ Yes \_\_\_\_\_ No **PLEASE ATTACH**



Speech and language services:

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Occupational therapy services:

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**Private services:** (List date placed, name of service provider, services received, and phone number)

Tutoring: \_\_\_\_\_

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Speech/language therapy: \_\_\_\_\_

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Occupational therapy: \_\_\_\_\_

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Does your child have a Learning plan/receive accommodations at school? \_\_\_\_\_ Yes \_\_\_\_\_ No  
**PLEASE LIST CURRENT ACCOMMODATIONS AND PROVIDE A COPY OF LEARNING PLAN**

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Has your child been granted accommodations on the PSAT, SAT, or ACT? \_\_\_\_\_ Yes \_\_\_\_\_ No  
**PLEASE LIST AND INCLUDE A COPY OF ACCOMMODATION LETTER**

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

\_\_\_\_\_

\_\_\_\_\_

Has your child ever repeated a grade? \_\_\_\_\_ If so, when? \_\_\_\_\_

What was the reason? \_\_\_\_\_

\_\_\_\_\_

**ATTACH A COPY OF THE MOST RECENT REPORT CARD AND STANDARDIZED TEST SCORES.**

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 and sign attached release of information form:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

**Payment is expected the first day of the evaluation.** The reimbursement by insurance coverage is a negotiation between you and your insurance representative. I do not accept deferred payment by your insurance carrier.

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: \_\_\_\_\_



## Authorization Form

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize my psychologist, \_\_\_\_\_ and/or her administrative and clinical staff, to release/receive information as follows: \_\_\_\_\_

\_\_\_\_\_  
(Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

This information should only be released to (name and address of person to whom the information is to be released)

\_\_\_\_\_  
I am requesting my psychologist to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

\_\_\_\_\_  
This authorization shall remain in effect until \_\_\_\_\_ (fill in expiration date) or until \_\_\_\_\_ (fill in an event that relates to the individual or the purpose of the use or disclosure).

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.