Dear Parents and Caregivers,

Thank you for taking the time to provide information about your child. This is a very important aspect of your child's evaluation. If you cannot remember some information, it is okay to leave blanks. We will further discuss relevant history at your appointment.

Child's name: _____ Today's date: _____
Child's age: _____ Child's date of birth: _____
Your name (first and last): _____ Your relationship to the child (i.e., father, step-parent, guardian): _____ Do you have legal custody of this child? YES / NO (circle one)

Who referred your child or recommended an evaluation?
□ Doctor □ Therapist/Counselor □ School □ Self □ Other _____
Name of the person who referred you: _____
As best as you are able, what are the reasons the above individual referred your child for evaluation (use additional paper if necessary)?

_____
_____
_____
_____
_____
_____

What are your main concerns at this point (again, use additional paper if necessary)?

_____
_____
_____
_____
_____

At what age were concerns first noted? _____
Has your child ever had treatment for these concerns? If so, what kind of treatment? With whom?

_____
_____

Is this child: □ biological □ adopted □ a foster child □ other _____
Who lives in the home with the child (parents, siblings, other family, others)?

_____
_____
_____

Does the child have other siblings that do not live at home? YES / NO (circle one)
Child's parents are:
□ married □ separated □ divorced □ never married □ living together
Parent/Guardian 1 Name: _____
highest grade/degree and occupation_____
Parent/Guardian 2 Name: _____
highest grade/degree and Occupation _____
Language(s) spoken at home? _____

In your child's family (parents, siblings, and both maternal and paternal grandparents, aunts, uncles, cousins), is there anyone with a history of (circle one):
Psychiatric Diagnosis (e.g., schizophrenia, personality disorder) YES/NO
Learning problems or difficulties in school YES/NO
Autism or Developmental Disorders YES/NO
Attention problems or diagnosed ADHD/ADD YES/NO
Behavior problems (e.g., defiant, oppositional, trouble with the law) YES/NO
Neurological Condition (e.g., seizures, stroke, brain tumor) YES/NO
Mental Retardation/Intellectual Disability YES/NO
Emotional Concerns (e.g., anxiety, depression, bipolar disorder) YES/NO
What supports do you currently have in raising your child? (check all that apply)
□ Maternal grandparents □ Paternal grandparents □ Friends □ Maternal/Paternal Siblings □ Community □ Other

Birth History Were there problems or complications with your pregnancy? Labor ? Delivery ?
_____
_____
At how many weeks gestation was this child born? _____
Birth weight (in pounds and ounces):_____
Was the child born (circle one): Vaginally / Cesarean section
Were any problems noted at birth or in the few days following? YES / NO
If Yes, please describe: _____
Age of mother at delivery: _____ Age of father at delivery: _____
Developmental History: Were there concerns about early feeding (e.g., poor suck, difficulty latching)? YES / NO (circle one)
Were there concerns about your child's motor development? YES / NO (circle one)
Were there concerns about your child's language development? YES / NO (circle one)
Were there concerns about toilet training? YES / NO (circle one)
At what age did/was your child: (it is okay to provide estimates if you are not sure)
Crawl _____ Walk _____ Speak first words _____ Put two words together _____ Toilet trained for bladder/urination _____ Toilet trained for bowel _____
Has he/she participated in physical therapy / occupational therapy / speech/language therapy? (circle) If yes, what were the concerns? At what ages was therapy provided?
_____
_____
_____
As an infant, was he/she:
□ fussy / difficult to comfort? □ "sickly" □over-sleepy
As a toddler or school-age child, did he/she have difficulty making friends? YES / NO
As a toddler or school-age child, did he/she have difficulty separating from parents? YES / NO
Which hand does he/she prefer to use: □ Right □ Left □ Both/No Preference

Does your child have a diagnosed medical condition, neurological disorder, developmental disorder, genetic syndrome, learning disability, or mental health diagnosis? If so, please specify:
_____
_____

Has your child ever had a seizure? YES / NO
Has your child ever had a head injury or traumatic brain injury (TBI)? YES / NO
Has your child ever had a concussion? YES / NO
Has child ever had a serious illness or been hospitalized? YES / NO
If you answered yes to any of the four above questions, please describe (use additional paper if necessary):

_____
_____
_____

Were ear tubes ever placed? YES / NO
Were there concerns about hearing? YES / NO
How often does child have headaches? _____
How often does child have stomach pain? _____
Does he/she have allergies / asthma? (circle) To what? _____
Does your child have any current problems with:
Vision YES NO Hearing YES NO Sleep YES NO Appetite YES NO
Please explain your child's bedtime routing and sleep schedule: _____

_____
_____

Please list all medications the child currently takes: _____

_____

Do you have concerns about sadness / depression / poor self-esteem in your child? YES / NO (circle one)
If so, please describe: _____

_____

Do you have concerns about anxiety / worry / compulsiveness in your child? YES / NO
If so, please describe: _____

_____

Do you have concerns about your child's ability to interact and get along with others? YES / NO
If so, please describe: _____

_____

This child gets along best with: □ Younger children □ Same age children □ Older children □ Adults
Any additional emotional or behavioral concerns? _____

_____
_____

What are your child's interests, hobbies, or activities/clubs? _____

_____
_____

Has your child ever participated in psychotherapy/counseling? YES / NO
If so, when and with whom? _____
Has your child ever been treated by a psychiatrist? YES / NO
If so, when and with whom? _____

Academic History Current School: _____
Current Grade: _____ Has he/she ever skipped / repeated (circle one) a grade? _____ Which grade? _____ Has he/she ever received special educational services in school? YES / NO If so, which grades? _____ What services were provided? _____
_____
Does your child currently have: □ Academic Intervention Services (AIS) □ an Individualized Educational Plan (IEP) □ a 504 plan □ no special education services
If so, what services / supports / accommodations / special instruction does he/she receive?
_____
_____
Do you or your child's teachers have concerns about progress/performance in: □ Math □ Reading □ Writing □ Spelling □ Social Studies/History □ Science
Did this child attend or receive: □ Early Intervention □ Preschool Special Education □ Preschool
Has your child had frequent school changes? YES / NO (circle one)

Please describe your child's strengths: _____
_____
_____
_____
Please describe your child's weaknesses: _____
_____
_____
_____
Is there any other information that you would like the psychologist to know?
_____
_____
_____
_____

Thank you! Please bring the following documents to your child's evaluation: • This completed questionnaire • Reports of previous psychological or educational evaluations (from school or private) • Current special education plans (i.e., 504 or IEP) • Copies of pertinent medical and mental health reports and evaluations