214.295.7615

Personal History

Date: ___________________ **Referred by:** _______________________

Child's Name: ____________________ **Date of Birth:** ___________________ **Age:** _________

Social Security #:___________________ **Gender: Male / Female** **Ethnicity:** ____________________________

Street Address: _____________________________**City:**_________________ **State:** _______ **Zip Code:** ____________

Home Phone #:________________ **Work #:**_________________**Cell #:**_______________________

E-mail (s):____

School: ___________________________________ **Grade:** ____________**Is the child in Special Education? Yes / No**

Has child repeated a grade? Yes / No. If yes, please explain____

Mother's Name: _________________________ **Age:** _____ **Highest Level of Education:** ____________________

Place/Type of Employment: ____

Father's Name: __________________________ **Age:** _____ **Highest Level of Education:** ____________________

Place/Type of Employment: ____

Are the parents (circle which) - ***Married*** ***Separated*** ***Divorced*** ***Never Married to One Another***

Is there another legal guardian besides the parent(s)? Yes / No If yes, please state name, address, phone number, and relationship to child (e.g., foster parent, grandparent, etc.):____
____

Is the child adopted? Yes / No **If yes, age when adopted:** ________________

Primary Language: ________________________ **Second Language:** ________________________________

Please list all other adults and children living in the home:

Name	***Age/Grade***	***Relationship to this child***	***Medical Educational/ Emotional Problems***

______________________ _________ _______________________ ____________________________

Name of person completing this form: ______________________________ **Relation to child:** ___________________

Child Care:
If primary caregivers work outside the home, please answer the following:

Who cares for your child when caregivers are gone? ____

How many hours per day is your child in a child-care setting? ____

How many different people care for your child? ____

Family Relations:
How does your child get along with brother(s) and/or sister(s)?

____

In which activities does the family participate together with this child?

____

What do you find most enjoyable about your child?

____

What do you find most difficult about raising your child?

____

Who is mainly in charge of discipline in the home? ________________________

Do all caregivers agree on discipline? __________________________________

Describe discipline techniques: _______________________________________

What is your primary concern regarding your child?

Describe the problem(s) your child is having and when the problem(s) began:

What issues, situations, or other problems have contributed to this difficulty?

Describe your child’s strengths.

Describe your child’s weaknesses.

What information/help do you hope to gain from this evaluation? What questions would you like answered?

DEVELOPMENTAL and MEDICAL HISTORY

PREGNANCY AND DELIVERY

Length of pregnancy (e.g., full term, 40 weeks, 32 weeks, etc.):__________ **Length of delivery (in hours):_________**

Mother's age when child was born: ________ **Child's birth weight: __________** **Was pregnancy planned?** Yes / No

Number of previous pregnancies: ________ Number of previous miscarriages:_______

Was a fertility specialist consulted? Yes / No Procedures:____

Please *circle* any of the following that occurred during pregnancy or delivery:

Unusual bleeding Excessive weight gain (more than 30 lbs.) Gestational Diabetes Toxemia/preeclampsia

Rh factor incompatibility Frequent nausea or vomiting High Blood Pressure Serious illness or injury

Took illegal drugs Used alcoholic beverages (amount__________) Smoked cigarettes Emotional Issues

Took prescription drugs (name of medications :____)

Medication to ease labor pains Forceps used during delivery Induced delivery

Breech delivery Cesarean section Other problems_______________

Please *circle* any of the following conditions if they affected your child during delivery or within the first few days after birth:

Injured during delivery Heart or lung distress during delivery Delivered with cord around neck

Born with a congenital defect Was in hospital more than 7 days Post Partum Depression

Needed oxygen Trouble breathing following delivery Was cyanotic, turned blue

Was jaundiced, turned yellow Had an infection Had seizures

Was given medications Jaundice- Bilirubin Lights? Yes / No. If yes, how long? ____________________________

Neonatal Care Yes / No. If yes, describe: ____

<u>Infant Health and Temperament:</u>

Please *circle* any of the following if they describe your child's behavior during his/her first 12 months:

Difficult to feed Difficult to get to sleep Colicky

Difficult to put on a schedule Cheerful Alert

Affectionate Sociable Easy to comfort

Difficult to keep busy Overactive, in constant motion Very stubborn, challenging

EARLY DEVELOPMENTAL MILESTONES:

At what age did your child first accomplish the following:

Smiled _______ Sat without help _______ Crawled _______ Stood _______

Fed self _______ Walked alone _______ Said first word _______ Said phrases _______

Bowel trained, day and night _______ Bladder trained, day and night _______ Dressed self _______

How do you feel your child developed? ____ Faster than average ____ Average ____ Slower than average

HEALTH HISTORY

Child's Pediatrician / Family Doctor: _______________________ Date of last physical exam:_________________

At any time has your child had the following:

	Never	Past	Present
Asthma	O	O	O
Allergies	O	O	O
Diabetes, Arthritis or other chronic illnesses	O	O	O
Epilepsy or seizure disorder	O	O	O
Febrile seizures	O	O	O
Chicken pox or other common childhood illness	O	O	O
Heart or blood pressure problems	O	O	O
High fevers (over 103º)	O	O	O
Headaches	O	O	O
Broken bones	O	O	O
Severe cuts requiring stitches	O	O	O
Head injury with loss of consciousness	O	O	O
Lead poisoning	O	O	O
Surgery	O	O	O
Lengthy hospitalization	O	O	O
Speech or language problems	O	O	O
Chronic ear infections	O	O	O
Hearing difficulties	O	O	O
Eye or vision problems	O	O	O
Fine motor / handwriting problems	O	O	O
Gross motor difficulties, clumsiness	O	O	O
Appetite problems (overeating or under eating)	O	O	O
Sleep problems (falling asleep, staying asleep)	O	O	O
Soiling problems	O	O	O
Wetting problems	O	O	O

Other health difficulties:

Diagnosis	Location	Date of Diagnosis	Diagnosing Physician

What was the date of you child's last vision exam? ___________________ Results? ______________________________

Has your child ever had tubes in their ears? Yes / No. If Yes, Date(s) ______________________Age(s)____________

Has your child ever been examined by an audiologist? Yes / No If Yes, When? ___________ Results? ___________

Please list prior surgeries.

Type of Surgery____Date____________Physician____________________
Type of Surgery____Date____________Physician____________________
Type of Surgery____Date____________Physician____________________
Type of Surgery____Date____________Physician____________________

Has your child received Chemotherapy? Yes / No If Yes, complete the following.

Dates of Treatment (inclusive)	Number of rounds	Type of chemotherapy	Side effects?

Date of last treatment: _____________________________ Are more scheduled at this time?________________________

Has your child received Radiation or Gamma Knife treatments? Yes / No If yes, complete the following:

Type of Treatment (i.e. radiation/gamma knife)	Dates of Treatment (inclusive)	Side Effects?

Date of last treatment?________________ Are more scheduled at this time? ____________________________________

List both prescription and over-the-counter medications your child is presently using for any physical conditions:

Medicine	Dosage	Reason for taking

Your child's overall general health is: ____ Excellent ____ Good ____ Fair ____ Poor
Your child's physical abilities compared to other children his/her age: (*Please Circle)*
Below Average Average Above Average

Has your child ever had Physical OR Occupational therapy? When? Where? How Often?

Your child's speech/language abilities compared to other children his/her age: (*Please circle)*
Below Average Average Above Average

Has your child ever had Speech Therapy? When? Where? How Often?

Have their ever been any concerns about his/her development?

____

____

FAMILY

Is there a pattern of physical illness in your family, which keeps repeating (e.g., heart disease, cancer, seizures, etc.)? If so, what?

____

____

____

Has your child or any other person in your family/extended family, including your self, experienced any of the following problems?

Concern	**Person(s) who experienced this/relationship to patient**
Anxiety	
Depression	
Bipolar Disorder	
Epilepsy	
Suicide	
Stuttering	
Explosive Temper	
Mental Retardation	
Learning Disabilities	
ADHD	
Schizophrenia	
Alcohol abuse	
Drug abuse	
Emotional Problems	
Other: __________________	

EDUCATION

List all schools your child has attended in chronological order:

Name of school	Location	School District	Grades Attended

Has your child ever received services through Early Childhood Intervention (ECI) or Pre-School Program for Children with Disabilities (PPCD)? Yes / No If yes, please identify which agency they received these services through and the ages during which your child received these services.

Does he/she have any learning problems in school? Yes / No. If yes, what are the problems?

At what age and grade were these problems first noticed?____________________

What actions were taken at that time? ____________________

Has he/she ever had psychological or educational testing for learning or behavior issues at school? Yes / No
If yes, for what issues? ____________________
When was date of last testing?____________**Results?**____________________

Is child receiving services under Section 504 or Special Education? Yes / No If yes, please describe all services they are currently receiving and those received in the past.

Have these services been helpful to your child? Yes / No

Has he/she ever repeated or skipped a grade? Yes / No If yes, which grade(s)?________________

How has his/her attendance been? ________**What types of grades?** ________**Have the grades changed a lot?** _____

Does he/she have any behavior or discipline problems at school? Yes No If yes, what problems?

What types of extracurricular school activities does your child participate in (e.g., clubs, band, drama, etc.)?________

Is there any family history of learning or school behavior problems in the family? Yes / No If yes, what were/are the problems and what is the individual's relationship to patient?

SOCIAL HISTORY

What are your child's major strengths? ____________________

What are your child's major weaknesses? ____________________

How many close friends does your child have? None 1 2 3 4 or more

Does your child have other friends besides those you would classify as "close" friends? Yes / No

What is the age range of his/her friends? ________ Are most of the friends older, younger or same age (circle which)?

How does your child get along with his/her friends? ____

Has there been a change in his/her circle of friends lately? Yes / No If yes, what has been the change? __________
____

Do his/her friends tend to get into trouble? Yes / No

What losses, changes, crises, and transitions do you believe have significantly impacted your child's life (e.g., divorce, arrests, graduation, moves, death in family, etc.)?____
____
____

Is there anything else about your child's lifestyle, including the family that would be helpful for me to know?
____
____

PSYCHOLOGICAL TREATMENT HISTORY

Has your child ever been in counseling before? Yes / No If so, with whom? _________________________________

What was the primary problem for which he/she was in counseling? ____
____

When was the counseling? ____________ For how long? ___________________ What was the outcome? _______
____

Has your child ever been hospitalized for emotional problems and/or alcohol/drug treatment? Yes / No
If so, when ________________________, where _______________________, outcome ____________________________
____

What medications has your child taken in the past for emotional problems? ____________________________________

What medications is your child currently taking for emotional problems? ______________________________________

Who is prescribing these medications? ____

Has your child ever completed psychological testing? Yes / No If so, with whom? ___________________________
When? __________________________ What was the diagnosis or recommendations? _________________________
____

BEHAVIORAL and EMOTIONAL CONCERNS

Please check any of the following if your child used to exhibit and/or presently exhibits any of these problems:
(Do not check if your child never exhibited the problem. "Now" means within the last 3-6 months)

	Past	Now
Thoughts of hurting self	____	____
Thoughts of committing suicide	____	____
Plans to commit suicide	____	____
Attempts to commit suicide	____	____

	Past	Now
Threats to commit suicide	____	____
Actually harmed someone	____	____
Thoughts of harming someone	____	____
Plans to harm someone	____	____
Attempts to harm someone	____	____
Threats to harm someone	____	____
Depressed or irritable mood most of the day for at least 2 weeks	____	____
Markedly lower interest or enjoyment in almost all activities	____	____
Significant weight loss, when not dieting	____	____
Significant weight gain	____	____
Decreased or increased appetite nearly every day	____	____
Insomnia at night or excessive sleep during the day, nearly every day	____	____
Agitated or excessive movement nearly every day	____	____
Lethargic, sluggish, slow moving nearly every day	____	____
Fatigue and loss of energy nearly every day	____	____
Feelings of worthlessness or excessive, inappropriate guilt nearly every day	____	____
Diminished ability to think or concentrate nearly every day	____	____
Recurrent thoughts of death	____	____
Recurrent thoughts of suicide	____	____
Was very depressed every day for at least two weeks	____	____
Was somewhat depressed or irritable more days than not over past 12 months	____	____

	Past	**Now**
Mood was unusually giddy, joyous or ecstatic for at least 1 week	____	____
Mood was persistently expansive (felt super-human or able) for at least 1 week	____	____
Mood was abnormally and persistently irritable for at least 1 week	____	____
***During the week or more he/she showed one of the above 3 moods did he/she*:**		
Have inflated self-esteem or felt grandiose about self	____	____
Show decreased need for sleep	____	____
Was more talkative than usual and seemed pressured to keep talking	____	____
Skip from one idea to another as if his/her ideas were flying rapidly by	____	____
State that his/her thoughts seemed to be racing	____	____
Become unusually persistent in accomplishing tasks	____	____
Seem very agitated, overly active, or abnormally restless	____	____
Showed excessive involvement in pleasurable but potentially harmful activities	____	____
Excessive anxiety and worry about a number of event or activities	____	____
Anxiety on most days for at least 6 months	____	____
Restless and feels on edge	____	____
Easily fatigued or tired	____	____
Difficulty concentrating or mind going blank	____	____
Irritability	____	____
Muscle tension	____	____
Difficulty falling asleep, staying asleep, or restless sleep	____	____
Unreasonable fear in social settings where others may notice or scrutinize him/her	____	____
Strong fear of being humiliated or embarrassed in front of others	____	____
Unreasonable, excessive fear of an object or situation (e.g., animal, heights, etc.)	____	____
Recurrent, excessive distress when separated from home or parent	____	____
Persistent worry that parent will leave or he/she will lose parent	____	____
Nightmares	____	____
Repeated complaints of headaches, stomachaches, nausea or vomiting	____	____

Repeated concerns about having a physical disorder or disease	____	____
Compulsively checks, counts, puts in order, or cleans, often in rigid fashion	____	____
Hears voices or sees things that are not really there	____	____
Believes that others are trying to harm him	____	____
Believes that others are controlling his mind	____	____
Is extremely suspicious of others	____	____
Others view his behavior and manner of speaking as odd or “crazy”	____	____
	Past	**Now**
Often loses temper	____	____
Often argues with adults	____	____
Often actively defies or refuses adults' requests or rules	____	____
Often deliberately annoys people	____	____
Often blames other for his/her mistakes or misbehavior	____	____
Is often touchy or easily annoyed by others	____	____
Is often angry or resentful	____	____
Is often spiteful or vindictive	____	____
Often bullies, threatens, or intimidates others	____	____
Often initiates physical fights		
Has used a weapon that can cause serious physical harm (e.g., gun, bat, brick, etc.)	____	____
Has been physically cruel to people	____	____
Has been physically cruel to animals	____	____
Has stolen while confronting a victim (e.g., mugging, purse snatching, etc.)	____	____
Has forced someone into sexual activity	____	____
	Past	**Now**
Has deliberately engaged in fire setting with intention of causing damage	____	____
Has deliberately destroyed others property (other than by fire setting)	____	____
Has broken into someone else's house, building, or car	____	____
Often lies or “cons” to obtain goods or favors and avoid obligation	____	____
Has stolen items without confronting a victim (e.g., shoplifting, forgery, etc.)	____	____
Often stays out at night despite parental prohibitions	____	____
Has run away from home, foster care, group home overnight	____	____
Is often truant from school	____	____
Often fails to give close attention to details or makes careless mistakes	____	____
Often has difficulty sustaining attention in tasks or play activities	____	____
Often does not seem to listen when spoken to directly	____	____
Often does not follow through on instructions and fails to finish work	____	____
Often has difficulty organizing tasks and activities	____	____
Often avoids, dislikes or is reluctant to engage in tasks requiring sustained effort	____	____
Often loses things necessary for tasks or activities (e.g., books, tools, pencils, etc.)	____	____
Is easily distracted by extraneous stimuli	____	____
Is often forgetful in daily activities	____	____
Often fidgets or squirms in seat	____	____
Often leaves seat in class or other situations where remaining seated is expected	____	____
Often runs or climbs excessively or feel restless and wants to move about	____	____
Often has difficulty playing quietly	____	____
Often talks excessively	____	____
Often blurts out answers before the other person has finished talking	____	____
Often interrupts or intrudes on others	____	____
Often has difficulty awaiting his/her turn	____	____

PLEASE ATTACH COPIES OF ALL AVAILABLE REPORT CARDS AND ALL STANDARDIZED TEST RESULTS, INCLUDING PREVIOUS PSYCHOLOGICAL OR EDUCATIONAL REPORTS THAT MAY BE APPLICABLE TO THIS ASSESSMENT