Please fill out all applicable areas of this form. If you do not know the information or it does not pertain to your child, leave the area blank.

What is the main reason you are seeking evaluation at this time? What are the chief concerns that you would like help with?

I. General Information

Child name (last, first)	Age	Grade	Birthdate
Person completing form	Relationship		Today's date
Parent/Guardian	Home phone		Work phone
Address	City	State	Zip
2nd Parent/Guardian	Home phone		Work phone
Address (if different)	City	State	Zip
Child's birthplace	Adopted? ▫Yes ▫No		If child was adopted, age at adoption

II. Family Background:

A. Birth Parents: This section pertains to the child's biological parents only. If you are not the child's birth parent, please complete as accurately as you can.

Birth mother's name:	Present age:
Highest level of formal education completed and degrees/certificates earned:	Current profession/occupation:
Live with child full time ☐ Yes ☐ No	Marital status: ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single, never married
Birth father's name:	Present age:
Highest level of formal education completed and Degrees/certificates earned:	Current profession/occupation:
Live with child full-time? ☐ Yes ☐ No	Marital status: ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single, never married

Child resides with: □ Birth mother & father □ Birth mother only □ Parent & stepparent □ Birth father only □ Parent & adoptive parent □ Adoptive parent(s) Guns in the home □ Yes □ No Second-hand smoke exposure? □ Yes □ No	If child lives with only one parent, contact with the other parent is: □ Frequent (sees child more than 4 days per week) □ Minimal (sees child less than once per week) □ None Pets, include reptiles and small pets:

B. **Siblings and Birth Order**: List the names and ages of each sibling in birth order, oldest child first, including relationship to the child (i.e., natural, half-sibling, step-sibling)

Name:	Age:	Male/Female:	Relationship:(natural,half-sibling,step-sibling)
1.			
2.			
3.			
4.			

C. Family History

Please check all that apply.

Condition	**Patient**	**Relative**	**Comments: please indicate any details regarding age of diagnosis, severity & treatment. If relative include the relationship to your child (example mom, dad, grandma, etc)**
Congenital defects/genetic disorders			
Infectious: recurrent ear infections, abscess, immune deficiency, HIV/AIDS, tuberculosis, hepatitis			
Pulmonary:asthma, cystic fibrosis, pneumonia			
Gastrointestinal: reflux(heartburn), inflammatory bowel disease, irritable bowel syndrome, celiac disease			
Cardiovascular: High blood pressure, high cholesterol, angina, heart attack, stroke, aneurysm, sudden death			
Hearing impairment or deafness			
Visual problems: blindness, “lazy eye”			
Learning, behavior, mental health, &neurological problems: • Autism, Asperger disorder • Inattention, Hyperactivity • Language delays • Headaches, seizures • OCD behaviors • Learning disability, Special education, mental retardation, down’s syndrome			
Hematologic: anemia, excessive bleeding, excessive blood clots, sickle cell trait/disease			
Endocrine: Diabetes (specify type I or II), thyroid conditions, polycystic ovarian disease(PCOS), or other hormone disorder			
Renal: Recurrent urinary tract infections, kidney infections, kidney reflux, polycystic kidney disease, dialysis			

Rheumatologic: Lupus, rheumatoid arthritis, other			
Psychiatric: Depression, anxiety, bipolar disorder, substance abuse, schizophrenia			
Cancer			

Other Medical Illnesses:

III. Child's Birth History: (Please respond to all items)

Were any chemical substances consumed during pregnancy? □ cigarettes □ alcohol □ marijuana □ other_____	
Were there any concerns during pregnancy, labor, and delivery? If yes, please explain:	
How was your child delivered? □ vaginal birth □ cesarean section	How many weeks gestation was your child at birth?
How many days after birth was infant released from the hospital? _____ Infant's weight at birth:_____	

IV. Education History

Early Intervention? (age 0-3) If yes, check all that apply and indicate how often (i.e. 1 hour/weekly)			
□ Speech/language therapy How often:_____	□ Occupational therapy How often:_____	□ Consultation with "interventionist" How often:_____	□ Structured play/social group How often:_____
Please describe any other types of therapies during ages 0-3:			

Was a multi-factored evaluation completed at age 3? □ Yes □ No
If yes, by which school district: _____

Preschool (year 1): □ special education □ inclusion setting □ private community school
Did staff relate any concerns to you about your child's development or classroom behavior? If so, please describe:
Preschool (year 2): □ special education □ inclusion setting □ private community school
Did staff relate any concerns to you about your child's development or classroom behavior? If so, please describe:
Preschool (year 3): □ special education □ inclusion setting □ private community school
Did staff relate any concerns to you about your child's development or classroom behavior? If so, please describe:

Between ages 3 and kindergarten did your child receive any therapies? If so please describe:

Elementary School Years

Kindergarten:	□ special education classroom	□ inclusion setting	□ regular education
1st grade:	□ special education classroom	□ inclusion setting	□ regular education
2nd grade:	□ special education classroom	□ inclusion setting	□ regular education
3rd grade:	□ special education classroom	□ inclusion setting	□ regular education
4th grade:	□ special education classroom	□ inclusion setting	□ regular education
5th grade:	□ special education classroom	□ inclusion setting	□ regular education
6th grade:	□ special education classroom	□ inclusion setting	□ regular education

Have teachers reported any concerns regarding academic and/or behavioral difficulties? If yes, please explain:

Middle School Years:
Have teachers reported any concerns regarding academic and/or behavioral difficulties? If yes, please explain:

High School Years:
Have teachers reported any concerns regarding academic and/or behavioral difficulties? If yes, please explain:

V. Medical Problems/History

Is this child presently on medication? (if you have a list, please attach)

Name of medication	Prescribed for:	(Helpful, Not Helpful)	Outcome	Unusual Reaction
1.				
2.				
3.				

Has this child previously been on medication?

Name of medication	Prescribed for:	(Helpful, Not Helpful)	Outcome	Unusual Reaction
1.				
2.				
3.				

Please indicate any allergies (include drug, food, etc): What problems did the allergy cause?

1.

2.

Please list any previous surgeries: Age Diagnosis

Please list any alternative therapies, home remedies, dietary supplement:

For girls: age at first menstrual period or none:	Regular? □ Yes □ No

<u>ONLY</u> if your child is here for an EEG evaluation please complete the following sections:

Has your child has any of the following? If yes, please explain.

Problem	**If yes, please check**	**Please explain:**
Staring spells		
Seizures (with or w/o fever)		
Head trauma		
Headaches		
Speech problems		
Tics or repeated movements		
Weight loss		
Rapid weight gain		
Trouble with appetite		
Unexplained fevers		
Vision problems		
Hearing problems		
Heart problems		
Hay fever/asthma		
Lung problems		
Diarrhea or constipation		
Stomach or bowel problem		
Urinary tract infection		
Kidney problems		
Broken bones or joint problems		
Skin problems		
Birth marks		
Endocrine problems		
Anemia (low blood)		
Immunologic problems		
Immunization reactions		
Other?		

Evaluation History:

Has your child participated in any assessments/evaluations or received treatment through a private professional, school or other agency? If yes, please list in order:

Name of Professional/Organization:	Purpose: Diagnosis:	Report available? □ yes □ no	Date of testing:
Name of Professional/Organization:	Purpose: Diagnosis:	Report available? □ yes □no	Date of testing:
Name of Professional/Organization:	Purpose: Diagnosis:	Report available? □ yes □ no	Date of testing:
Name of Professional/Organization:	Purpose: Diagnosis:	Report available? □yes □ no	Date of testing:
Name of Professional/Organization:	Purpose: Diagnosis:	Report available? □ yes □ no	Date of testing:

Has your child had any EEG's, CT scans, or MRI scans?

EEG □ Yes □ No If yes, when: _____ where: _____ outcome: _____

CT □ Yes □ No If yes, when: _____ where: _____ outcome: _____

MRI □ Yes □ No If yes, when: _____ where: _____ outcome: _____