



Dear Parents:

Your completion of this form will greatly help in understanding your child, adolescent, or young adult (referred to as "client" below). This information is confidential and will not be released without written permission from you; however, there are some exceptions to confidentiality, which are discussed in detail on the Consent Form. This data is useful in understanding the questions to be answered by the evaluation and may be referred to in the written report. If extra space is needed, please feel free to attach additional pages for your comments.

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

Person(s) filling out this form: Father \_\_\_\_\_ Mother \_\_\_\_\_ Other \_\_\_\_\_

**I. IDENTIFYING DATA**

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Date of Birth \_\_\_\_\_ School \_\_\_\_\_

Current Grade \_\_\_\_\_

Child lives with \_\_\_\_\_

at \_\_\_\_\_

(address, city, state, zip)

\_\_\_\_\_  
(area code & home phone number)

\_\_\_\_\_  
(cell phone number)

\_\_\_\_\_  
(e-mail address)

\* In cases of custody agreements, single-parenthood, or legal guardianship being assumed by person(s) other than a biological parent, The Center for Family & Children is required to have documentation of the court-ordered custody agreement with submission of paperwork. Failure to provide this information will delay your appointment.

Referred by \_\_\_\_\_

**List names, as appropriate:**

Father \_\_\_\_\_

Step-father \_\_\_\_\_

Mother \_\_\_\_\_

Step-mother \_\_\_\_\_

How often does the child visit the non-resident parent? \_\_\_\_\_

**Present Occupation of resident parents:**

Father (step-father) \_\_\_\_\_ Business phone \_\_\_\_\_

Mother (step-mother) \_\_\_\_\_ Business phone \_\_\_\_\_

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PURPOSE OF THIS EVALUATION:

What questions would you like answered by this evaluation? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This child's strengths include \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I believe this child's main difficulty to be \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For whom is the report intended (e.g., present school, future school, physicians, etc.)?  
\_\_\_\_\_  
\_\_\_\_\_

**II. DEVELOPMENTAL HISTORY**

A. Was this child adopted? \_\_\_\_\_ If yes, age at time of adoption \_\_\_\_\_ Has this child been told (s)he was an adopted child? \_\_\_\_\_

B. Mother's medical history during pregnancy:

This child was which of the total number of pregnancies (1<sup>st</sup>, 2<sup>nd</sup>, etc.)? \_\_\_\_\_

When did prenatal care begin? \_\_\_\_\_

Was the birth mother treated for any of the following? (Give the approximate month of pregnancy)

1. Convulsions \_\_\_\_\_

2. Infections \_\_\_\_\_

a. Virus \_\_\_\_\_

b. Measles \_\_\_\_\_

c. Hepatitis \_\_\_\_\_

d. Toxemia \_\_\_\_\_

e. Other \_\_\_\_\_

3. What medications were taken during pregnancy? \_\_\_\_\_

When? \_\_\_\_\_

4. Were the following factors present during pregnancy?

a. Pelvic irradiation \_\_\_\_\_

b. Unusual nutritional factors \_\_\_\_\_

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- c. Uterine abnormalities \_\_\_\_\_
- d. RH incompatibility \_\_\_\_\_
- e. Bleeding \_\_\_\_\_ When? \_\_\_\_\_ Duration \_\_\_\_\_
- f. Accidents during pregnancy \_\_\_\_\_
- g. Emotional pressures during pregnancy (describe briefly) \_\_\_\_\_

**III. OBSTETRICAL HISTORY FOR THIS CHILD**

Where was child born \_\_\_\_\_

Length of pregnancy \_\_\_\_\_

Length of labor (approximate hours) \_\_\_\_\_

Spontaneous? \_\_\_\_\_ Induced? \_\_\_\_\_

Delivery:

a. Was delivery rapid? (how quickly?) \_\_\_\_\_

b. Position normal? \_\_\_\_\_

c. Forceps assisted? \_\_\_\_\_

d. By planned or unplanned Cesarean section? \_\_\_\_\_

e. If placed in incubator, for how long? \_\_\_\_\_

f. Weight at birth \_\_\_\_\_ lbs., \_\_\_\_\_ oz. Color at birth \_\_\_\_\_

Child's first year:

a. Active \_\_\_\_\_ Passive \_\_\_\_\_ Contented \_\_\_\_\_ Fretful \_\_\_\_\_

Was the baby breast-fed? \_\_\_\_\_ How long? \_\_\_\_\_

b. Colic? \_\_\_\_\_ Describe \_\_\_\_\_

c. Volatile vomiting? \_\_\_\_\_

d. Digestive problems? \_\_\_\_\_

e. Allergies? \_\_\_\_\_

f. Was there difficulty in establishing sleep patterns? \_\_\_\_\_

g. Were medications prescribed in the first year? \_\_\_\_\_

If so, what medication (or type) \_\_\_\_\_ Why given? \_\_\_\_\_

#### IV. DEVELOPMENTAL HISTORY OF CHILD

Behavior	Age Accomplished	Comments About the Achievement
held head erect		
rolled from back to stomach		
first tooth		
sat unsupported		
crept or crawled/how long		
stood alone		
walk unattended		
drank from a cup		
weaned		
ate alone with spoon		
first words spoken		
talked in short sentences		
talked clearly enough that strangers understood		
became toilet trained		(easily/difficult)
learned to skip		
began bicycle riding with training wheels		
began bicycle riding without training wheels		

#### V. MEDICAL HISTORY OF CHILD

If the child has had any of the following, give approximate age if actual age is not remembered.

Mumps \_\_\_\_\_ Measles \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Meningitis \_\_\_\_\_

Frequent headaches \_\_\_\_\_ Hearing problems \_\_\_\_\_ Stomach upsets \_\_\_\_\_

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Frequent colds \_\_\_\_\_ Whooping Cough \_\_\_\_\_ Hay Fever \_\_\_\_\_  
Sore throats \_\_\_\_\_ Cerebral Palsy \_\_\_\_\_ Ear infections \_\_\_\_\_  
High fevers: Age \_\_\_\_\_ Cause \_\_\_\_\_ How high \_\_\_\_\_  
How long \_\_\_\_\_  
Allergies to \_\_\_\_\_  
Comments \_\_\_\_\_

Please describe any other medical conditions \_\_\_\_\_

Describe any serious accidents this child has had \_\_\_\_\_

Age at time of accident \_\_\_\_\_ Actions taken \_\_\_\_\_

Treatment given \_\_\_\_\_

Hospitalizations (state age, duration and reason) \_\_\_\_\_

This child was last seen by Dr. \_\_\_\_\_ Date \_\_\_\_\_  
(Please print first and last names)

The physical examination revealed \_\_\_\_\_

Is this child taking any medication? \_\_\_\_\_ What? \_\_\_\_\_

Dosage \_\_\_\_\_ Prescribed by \_\_\_\_\_ How long \_\_\_\_\_

Any other medications taken in the last twelve months? \_\_\_\_\_

Hearing has/has not been checked:  
at school \_\_\_\_\_; in doctor's office \_\_\_\_\_; by an Audiologist \_\_\_\_\_ Date \_\_\_\_\_  
Results: adequate/inadequate. If inadequate, please explain \_\_\_\_\_

Vision has/has not been checked:

at school \_\_\_\_\_; in doctor's office \_\_\_\_\_; by an ophthalmologist/optometrist \_\_\_\_\_

Date \_\_\_\_\_

Results: adequate/inadequate. If inadequate, please explain \_\_\_\_\_

Is this child on a special diet? \_\_\_\_\_ Restrictions \_\_\_\_\_

## VI. FAMILY HISTORY

Present health of immediate family members \_\_\_\_\_

Additional comments \_\_\_\_\_

List by name the members of this child's family. Please include parents, step-parents, full, half, and step-siblings.

Name of Family Member	Relationship to This Child	Age	Highest Year of School Completed	Name Any Grade Repeated	Reading, Writing, Math or Speech/ Language Problems? If so, which and when?

Please note a history of the following illnesses/difficulties (cousins, aunts, uncles, and grandparents, as well as immediate family members, are to be included):

<b>Illness/Difficulty</b>	<b>Check if Yes</b>	<b>When Occurred</b>	<b>Relationship to Child (e.g., maternal aunt)</b>
Convulsive Seizures			
Autism Spectrum Disorders			
Mental Retardation			
Drug Addiction			
Criminal Record			
Depression			
Bipolar Disorder			
Psychotic Disorder/ Schizophrenia			
Anxiety Disorders			
Articulation Problems			
Deafness			
Reading, Writing, Spelling Problems (note which)			
Mathematics Difficulty			
Hyperactivity			
Attention Problems			

**VII. SCHOOL HISTORY**

Daycare program? \_\_\_\_\_ from age \_\_\_\_\_ to \_\_\_\_\_

Preschool program? \_\_\_\_\_ from age \_\_\_\_\_ to \_\_\_\_\_

Name and location of preschool program(s): \_\_\_\_\_

List the names of schools attended beginning with kindergarten:

School Name	Child's Age	Grade	City/State	School System (public/private)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Was entry into first grade delayed by attending Kindergarten twice or a pre-first grade? \_\_\_\_\_

Current School Data:

a. The child's best subject(s) is/are \_\_\_\_\_

b. Grade history (general) \_\_\_\_\_

c. Please list your child's most recent grades \_\_\_\_\_

d. Does your child finish his/her work in class? Yes \_\_\_\_\_ No \_\_\_\_\_

e. Does your child have trouble paying attention? Yes \_\_\_\_\_ No \_\_\_\_\_

f. Does your child have trouble staying in his/her seat when asked? Yes \_\_\_\_\_ No \_\_\_\_\_

g. Does your child have difficulty working independently? Yes \_\_\_\_\_ No \_\_\_\_\_

h. Has your child had (or having) special help at school? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, what type (e.g., tutoring, speech therapy, resource room) and when? Please describe.

Homework: Done easily? \_\_\_\_\_ With difficulty? \_\_\_\_\_



Needs help with (describe) \_\_\_\_\_

Source of help: At Home \_\_\_\_\_ At School \_\_\_\_\_

Studies: When \_\_\_\_\_ Where \_\_\_\_\_

How long? \_\_\_\_\_

Puts off studying until last minute \_\_\_\_\_

Does your child like school? \_\_\_\_\_ Comments \_\_\_\_\_

What does the teacher think the problem is? \_\_\_\_\_

What does the teacher think about the child's behavior? (e.g., general attitude, response when corrected, relationship with classmates, etc.) \_\_\_\_\_

**VIII. BEHAVIOR**

This child has had or is still having problems with which of the following:

	What Age(s)	How Often
Bullying	_____	_____
Shyness	_____	_____
Withdrawn from peers	_____	_____
Aggressive behaviors	_____	_____
Appears anxious	_____	_____

This child has had or is still having problems with which of the following:

	What Age(s)	How Often
Fear of darkness	_____	_____
Restlessness	_____	_____
Daydreaming	_____	_____
Truancy	_____	_____
Fighting	_____	_____
Temper tantrums	_____	_____

Resenting discipline \_\_\_\_\_  
Bad dreams \_\_\_\_\_  
Other (please describe) \_\_\_\_\_

Has this child ever had contact with the police or juvenile authorities? If so, please explain.

Please describe any unusual behavior patterns your child possesses (positive or negative).

What activities does the family do together? \_\_\_\_\_

Describe how this child gets along with:

Father \_\_\_\_\_

Mother \_\_\_\_\_

Brothers \_\_\_\_\_

Sisters \_\_\_\_\_

Step family members in home \_\_\_\_\_

Others in home \_\_\_\_\_

Comments \_\_\_\_\_

This child will talk more freely with (mother, father, sister, brother, other; give relationship)

This child seems to get most upset when \_\_\_\_\_

This child seems happiest when \_\_\_\_\_

## **IX. RECREATION AND INTERESTS**

This child has (many, average, few, no) friends.

In recreational activities, this child most often prefers the company of others (younger, older, his/her own age).

If he/she could, he/she would like to have (many, few) friends; do things (alone, with just one friend, in a group).

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This child likes best to associate with (boys, girls, both the same).

This child seems to enjoy most those games that are (rough, noisy, quiet; require a great deal of make-believe; require little physical activity; have definite rules).

This child, when losing a game, usually (loses his/her temper, keeps right on playing, works even harder, seems to "give up," blames someone or something for the loss, gets discouraged and wants to quit).

This child likes best to socialize (at home, at someone else's house).

This child likes best to "make rules" and decide how things will go or have someone else make the decisions.

This child (likes, dislikes) close attention or supervision.

What does she/he like to do for recreation? \_\_\_\_\_  
\_\_\_\_\_

This child takes part in which of the following activities outside of home or school:

Scouts \_\_\_\_\_ YMCA \_\_\_\_\_ Clubs \_\_\_\_\_ Youth Groups \_\_\_\_\_ Other \_\_\_\_\_

Please describe any unusual behavior (positive or negative) you have observed at these activities:

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

What plans do you have for changes in such areas as family, school, social, medical, etc., that have not been mentioned elsewhere in this questionnaire?

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

#### **X. OTHER SPECIALISTS CONSULTED**

Name \_\_\_\_\_ Date \_\_\_\_\_

Agency \_\_\_\_\_ City \_\_\_\_\_

Their findings/recommendations \_\_\_\_\_

**Please send copies of all test/evaluation reports,  
including Special Education paperwork**

Any additional information you feel will be helpful to us may be written below or on a separate sheet.

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