

FAMILY INFORMATION Continued

PARENT(S)/GUARDIANS INFORMATION: MOTHER

Name: _____ Date of Birth: _____ Age: _____
Job Title: _____ Employer: _____ Work Phone: _____
Age at time of pregnancy: _____ Was the pregnancy planned? Yes No
Education: Highest Degree Completed: _____
Attention Problems: _____
Learning Problems: _____
Behavior Problems: _____

Mother's Medical Problems:

Diabetes Cardiovascular Cancer Asthma High Blood Pressure Thyroid
 Emphysema Obesity Allergies HIV/AIDS Anemia Ulcers
 Lupus MS ALS Stroke Seizure Disorder Epilepsy
 Other: _____

Mother's Mental Health Problems:

Depression Anxiety Bi-Polar Eating Disorder Schizophrenia
 Substance Dependence If Yes, which substances? _____
 Other _____

PARENT(S)/GUARDIANS INFORMATION: FATHER

Name: _____ Date of Birth: _____ Age: _____
Job Title: _____ Employer: _____ Work Phone: _____
Education: Highest Degree Completed: _____
Attention Problems: _____
Learning Problems: _____
Behavior Problems: _____

Father's Medical Problems:

Diabetes Cardiovascular Cancer Asthma High Blood Pressure Thyroid
 Emphysema Obesity Allergies HIV/AIDS Anemia Ulcers
 Lupus MS ALS Stroke Seizure Disorder Epilepsy
 Other: _____

Father's Mental Health Problems:

Depression Anxiety Bi-Polar Eating Disorder Schizophrenia
 Substance Dependence If Yes, which substances? _____
 Other _____

III. PREGNANCY AND BIRTH HISTORY Biological Child Adopted Child

Duration of Pregnancy (weeks) _____ Unknown

Pregnancy History/Complications (please check all that apply):

Severe nausea/vomiting Hospitalization required
 Severe staining blood loss Threatened miscarriage
 Infections..... Specify: _____
 Toxemia
 Surgery..... Specify: _____
 Other illnesses..... Specify: _____
 Smoking during pregnancy Number of cigarettes per day _____
 Occasional Alcohol Use Regular Alcohol Use
Alcohol use per day _____
 Medications taken
 X-ray studies

PREGNANCY AND BIRTH HISTORY Continued

Delivery History/Complications:

- Type of labor: Spontaneous Induced
- Duration of labor: Hours
- Type of Delivery: Normal Breach Caesarean Section
 Forceps Suction
- Complications: Cord around neck Hemorrhage
 Blood incompatibility Premature
 Other fetal distress Specify: _____

Birth Weight lbs. ozs. Apgar Scores /

Post Delivery Period:

- Jaundice Cyanosis Transfusion
 Incubator care Infection Specify: _____

IV. DEVELOPMENTAL HISTORY

Infancy: (please check all that were observed to a significant degree)

- Did not enjoy being cuddled Difficulty nursing/feeding
 Difficult to control Colic
 Irritable Restless
 Difficulty sleeping Head banging
 Constant crying Was not calmed by being held or stroked
 Constantly into everything when began creeping/walking

Please record the age at which your child achieved the following developmental milestones (Early, normal, or late compared with typical children):

<u>Behavior</u>	<u>Age</u>	<u>Early</u>	<u>Normal</u>	<u>Late</u>	<u>Not Achieved (Explain)</u>
Smiling	_____	_____	_____	_____	_____
Sat without support	_____	_____	_____	_____	_____
Crawled	_____	_____	_____	_____	_____
Stood without support	_____	_____	_____	_____	_____
Walked without assistance	_____	_____	_____	_____	_____
Spoke first words	_____	_____	_____	_____	_____
Spoke phrases	_____	_____	_____	_____	_____
Spoke sentences	_____	_____	_____	_____	_____
Bladder control: day	_____	_____	_____	_____	_____
Bladder control: night	_____	_____	_____	_____	_____
Bowel control: day	_____	_____	_____	_____	_____
Bowel control: night	_____	_____	_____	_____	_____
Fed self	_____	_____	_____	_____	_____
Dressed self	_____	_____	_____	_____	_____
Buttoned clothing	_____	_____	_____	_____	_____
Tied shoelaces	_____	_____	_____	_____	_____
Zipped clothing	_____	_____	_____	_____	_____
Rode tricycle	_____	_____	_____	_____	_____
Rode bicycle	_____	_____	_____	_____	_____
With training wheels	_____	_____	_____	_____	_____
Without training wheels	_____	_____	_____	_____	_____
Named colors	_____	_____	_____	_____	_____
Counted to 10	_____	_____	_____	_____	_____
Named coins	_____	_____	_____	_____	_____
Said alphabet in order	_____	_____	_____	_____	_____
Showed interest in books	_____	_____	_____	_____	_____
Began to read	_____	_____	_____	_____	_____

Toddler Temperament:

- Activity Level..... High Average Lethargic
- Distractibility..... Significant Average Non-significant
- Adaptability..... Comfortable w/change Average Upset by change
- Approach/Withdrawal Accepted new things Average Poor acceptance
- Intensity..... Expressed feelings strongly Average Feelings rarely expressed
- Usual Mood..... Content Angry Sad Anxious
- Regularity..... Predictable sleep/feeding pattern Unpredictable/inconsistent

V. MEDICAL HISTORY

Family Health History. Please check any conditions listed below that apply to relatives of the child. Next to it, please write that person's relationship to the child. Relatives include the child's siblings, parents, grandparents, aunts, uncles, and cousins on both sides of the family.

Condition	Relationship to Child
<input type="checkbox"/> Seizures, convulsions, epilepsy	_____
<input type="checkbox"/> Cerebral palsy	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Muscular weakness	_____
<input type="checkbox"/> Poor coordination, clumsy	_____
<input type="checkbox"/> Slow motor development	_____
<input type="checkbox"/> Deformities	_____
<input type="checkbox"/> Early deaths	_____
<input type="checkbox"/> Severe visual impairment	_____
<input type="checkbox"/> Hearing loss	_____
<input type="checkbox"/> Speech problems or late talker	_____
<input type="checkbox"/> Minimal brain dysfunction	_____
<input type="checkbox"/> Mental retardation	_____
<input type="checkbox"/> Slow development	_____
<input type="checkbox"/> Brain damage	_____
<input type="checkbox"/> School difficulties	_____
<input type="checkbox"/> Reading difficulty	_____
<input type="checkbox"/> Learning disabilities	_____
<input type="checkbox"/> Emotional/behavioral problems	_____
<input type="checkbox"/> Attention Deficit Disorder	_____
<input type="checkbox"/> Autism, PDD, Asperger's	_____
<input type="checkbox"/> Psychiatric Disorder (specify)	_____
<input type="checkbox"/> Odd social/eccentric personality	_____
<input type="checkbox"/> Tics or sudden unplanned movements	_____
<input type="checkbox"/> Tourette's Syndrome	_____
<input type="checkbox"/> Neurofibromatosis	_____
<input type="checkbox"/> Tuberous sclerosis	_____
<input type="checkbox"/> Fragile X	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Immune system problems	_____
<input type="checkbox"/> Thyroid disease	_____
<input type="checkbox"/> Kidney disease	_____
<input type="checkbox"/> Heart disease	_____
<input type="checkbox"/> Heavy drinking	_____
<input type="checkbox"/> Other (specify) _____	_____

Child's Medical History

Childhood Diseases	Age	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL HISTORY Continued

If your child's medical history includes any of the following, please indicate the age of occurrence and any other relevant information:

- Hospitalization _____
- Surgery _____
- Accidents _____
- Head Injury Cause: _____ Coma? _____ How long? _____
- High fevers _____
- Convulsions Notes: _____
- Eye problems _____
- Allergies/Asthma _____
- Poisoning _____
- Headaches _____
- Respiratory problems _____
- Eating disorder _____
- Speech problems _____
- Addictions _____
- Failure to thrive _____

Seizure Disorder Yes No
History of Convulsions Yes No Details: _____

Epilepsy Yes No
If yes provide: Age of 1st seizure _____ Severity of initial seizure: _____
Precipitant to initial seizure: fever virus head injury other: _____
Medication: _____

Abuse History

Has your child been abused? Physically YES NO
Sexually YES NO
Emotionally YES NO

If yes, please give details: _____

Hospitalization

Has your child ever been hospitalized for problems related to emotional or behavioral disturbance, and/or drug or alcohol use? YES NO
If yes, what behaviors precipitated the hospitalization? _____

VI. PRESENT MEDICAL STATUS

Height _____ Weight _____ Abnormal growth patterns _____

Present illness for which the child is being treated: _____

Does your child take any prescription medication on a regular basis? Yes No

*List both medical and psychiatric medications

Medication	Dosage	Taken for?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

At this time, my child's health is: Excellent Good Fair Poor

VII. ACADEMIC HISTORY

Rate your child's overall school success:

Pre-school	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Kindergarten	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Early Elementary (1-3)	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Late Elementary (4-6)	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Middle School	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
High School	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor

High School Graduate? Yes No GED

Rate your child's current academic level:	Above Grade Level	At Grade Level	Below Grade Level
	Level		Level
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mathematics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sciences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language Arts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has your child ever been retained? Yes No

What were the reasons for the retention? _____

Has your child ever been suspended from school? Yes No When? _____

What were the reasons for the suspension? _____

Has your child ever been expelled from school? Yes No When? _____

What were the reasons for the expulsion? _____

Has your child ever been evaluated by a school psychologist? Yes No When? _____

Reasons for evaluation and findings: _____

Has your child received special education services? Yes No Type of Service: _____

Disability condition: _____

ACADEMIC HISTORY Continued

Please check any of the following behaviors that describe your child at school:

- | | |
|---|--|
| <input type="checkbox"/> Difficulty understanding spoken language | <input type="checkbox"/> Difficulty maintaining attention |
| <input type="checkbox"/> Difficulty following verbal directions | <input type="checkbox"/> Easily distracted |
| <input type="checkbox"/> Loses or forgets things | <input type="checkbox"/> Always late |
| <input type="checkbox"/> Difficulty expressing thoughts or ideas | <input type="checkbox"/> Limited speaking vocabulary |
| <input type="checkbox"/> Underactive | <input type="checkbox"/> Overactive, can't stay seated |
| <input type="checkbox"/> Difficulty with basic reading skills | <input type="checkbox"/> Difficulty with organization |
| <input type="checkbox"/> Difficulty with reading comprehension | <input type="checkbox"/> Avoids doing written work |
| <input type="checkbox"/> Difficulty reading grade level texts and worksheets | <input type="checkbox"/> Poor test grades |
| <input type="checkbox"/> Avoids school | <input type="checkbox"/> Doesn't participate in class |
| <input type="checkbox"/> Difficulty with spelling | <input type="checkbox"/> Difficulty with basic math problems |
| <input type="checkbox"/> Difficulty with writing mathematics | <input type="checkbox"/> Difficulty with math word problems |
| <input type="checkbox"/> Difficulty organizing thoughts and ideas into paragraphs | <input type="checkbox"/> Needs constant approval |
| <input type="checkbox"/> Lacks motivation | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Sudden changes in mood | <input type="checkbox"/> Shy or withdrawn |
| <input type="checkbox"/> Lacks self-control | <input type="checkbox"/> Difficulty keeping or making friends |
| <input type="checkbox"/> Difficulty remembering information | <input type="checkbox"/> Avoids accepting responsibility |
| <input type="checkbox"/> Unusually aggressive | <input type="checkbox"/> Oppositional/defiant with teacher |
| <input type="checkbox"/> Difficulty with social interaction | <input type="checkbox"/> Is often bullied/picked on by others |
| <input type="checkbox"/> Easily influenced by others | <input type="checkbox"/> Bullies others |
| <input type="checkbox"/> Appears to have poor judgment | <input type="checkbox"/> Intrudes into the space of others |
| <input type="checkbox"/> Doesn't appear to learn from mistakes | <input type="checkbox"/> Impulsive |
| <input type="checkbox"/> Fidgety with hands; squirmy when has to sit still | <input type="checkbox"/> Intrudes into the space of others |
| <input type="checkbox"/> Can't stay seated or still for a reasonable period | <input type="checkbox"/> Impulsive |
| <input type="checkbox"/> Easily distracted by extraneous activity or noise | <input type="checkbox"/> Appears not to listen to instructions |
| <input type="checkbox"/> Has difficulty waiting turn in games or group situations | <input type="checkbox"/> Loses things |
| <input type="checkbox"/> Interrupts; doesn't wait for others to stop speaking | <input type="checkbox"/> Seems to have poor memory |
| <input type="checkbox"/> Has problem following through with instructions | <input type="checkbox"/> Poor self-control/self-discipline |
| <input type="checkbox"/> Has difficulty staying focused during play | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Shifts from one uncompleted task to another | <input type="checkbox"/> Difficulty handling frustration |
| <input type="checkbox"/> Has difficulty playing quietly | <input type="checkbox"/> Unpredictable |
| <input type="checkbox"/> Non-stop talker | <input type="checkbox"/> Sudden physical aggression towards other children |
| <input type="checkbox"/> Resentful of siblings | <input type="checkbox"/> Appears not to listen to instructions |
| <input type="checkbox"/> Boundless energy | <input type="checkbox"/> Could be described as "different" |
| <input type="checkbox"/> Moody | <input type="checkbox"/> Creates more problems at home than siblings do |

VIII. OTHER BEHAVIORAL CONCERNS

Is your child actively psychotic? Yes No Please explain: _____

History of Illegal Drug Use? Yes No Active use? Yes No Describe: _____

History of suicide attempts? Yes No Actively suicidal? Yes No Describe: _____

OTHER BEHAVIORAL CONCERNS Continued

History of assault/violence? Yes No Describe: _____

Has your child ever been arrested? Yes No If yes, for what reason and when? _____

Any legal problems/current litigation? Yes No When? _____
If yes, please give details _____

History of prescription drug theft? Yes No If yes describe: _____

Is your child currently prescribed benzodiazepines? Yes No If yes provide details: _____

IX. INTERESTS & ACCOMPLISHMENTS

What are your child's main interests or hobbies? _____

What are your child's greatest accomplishments? _____

What does your child enjoy? _____

What does your child dislike? _____

What do you like about your child? _____

What do you wish were different about your child? _____

