Ariella Soffer, Ph.D. PLLC

330 West 58th Street, Suite 409

New York, NY 10019

646.300.5095

Child's Name_____ **Date**_____

Child's Birth date_____ **Age**_____

Legal Guardian(s):

Name	Phone (H)	Phone (W)	Job Title/Firm Name
_____	_____	_____	_____
_____	_____	_____	_____

Legal guardian is (check one):

Biological parent(s)_____

Relative (specify relationship)_____

Other (specify relationship)_____

Child's Address (Street, City, State, Zip)_____

_____

Child's Primary Language_____ Child's Secondary Language_____

Child's Current Grade in School_____

School Attending_____

Medical Diagnosis (if any)_____

Medication (if any)_____

Who referred your child?_____

Describe the problems, first major concerns and then minor ones:_____

_____

_____

_____

Symptoms (note those that apply)	Rate How Severe 1-mild; 2-moderate; 3-severe
Sadness/Depression	_____
Anxiety/Nervousness	_____
Stress	_____
Sleeping Problems	_____
Becoming Angry/Irritable more easily	_____
Euphoria (feeling on top of the world)	_____
Much more emotional	_____
Feel as if he/she doesn't care anymore	_____
Doing things automatically (without awareness)	_____
Less inhibited (doing things wouldn't do before)	_____
Difficulty being spontaneous	_____
Change in eating habits	_____
Other recent changes in behavior/personality	_____

Describe other if applicable: _____

EARLY HISTORY

Child was born: On time_____ Prematurely_____ Late_____

If premature, how many weeks' gestation?_____

Weight at birth_____lbs. _____oz.

Were there any problems associated with your child's birth (e.g., oxygen deprivation, unusual birth position, etc.) or the period immediately afterward (e.g., need for oxygen, special equipment used, convulsions, illness, etc.)?

Yes_____ No_____

If yes, please describe:_____

Check all that applied to child's mother while she was pregnant:

_____ Accident
_____ Alcohol use
_____ Cigarette smoking
_____ Drug use (marijuana, speed, cocaine, LSD, prescription drug abuse, etc.)
_____ Illness (toxemia, diabetes, high blood pressure, infection, Rh incompatibility, etc.)
_____ Poor nutrition
_____ Psychological problems
_____ Other problems_____

MEDICAL HISTORY

Has your child received any significant medical diagnoses that have required ongoing treatment?
If yes, please describe:

Has your child had an accident or illness, which required a hospital visit? Yes_____ No_____

If yes, describe what happened:_____

Did your child ever suffer a serious injury to his/her head? Yes_____ No_____

If yes, please explain the circumstances and any problems your child had afterward_____

_____

_____

How would you describe your child's nutrition? Excellent_____ Average_____ Poor_____

Child's Pediatrician (Name, Phone Number, Address):

_____

FAMILY HISTORY

The following questions deal with your child's **biological** mother, father, brothers, and sisters.

Mother

What is mother's name (Include maiden name)?_____

Is she alive? Yes_____ No_____ If deceased, what was the cause of death?_____

Mother's occupation_____

Mother's level of education_____

Has mother had mental health treatment? If so, please describe what was treated:

_____

_____

Father

What is father's name?_____

Is he alive? Yes_____ No_____ If deceased, what was the cause of death?_____

Father's occupation_____

Father's level of education_____

Has mother had mental health treatment? If so, please describe what was treated:

_____

_____

How many brothers does child have_____

How many sisters does child have_____

Where is child in the birth order_____

Are there any unusual problems (physical, academic, psychological) associated with any of child's brothers or sisters? Yes_____ No_____

If yes, please describe_____

PERSONAL HISTORY

EDUCATIONAL HISTORY
Please list all schools your child has attended, note if there were any concerns about your child at that school, and indicate what interventions were implemented:

School Name Concerns Interventions

Preschool_____ _____ _____

Elementary_____ _____ _____

High School_____ _____ _____

Was your child ever held back to repeat a grade? Yes_____ No_____

If yes, what grade(s)?_____ and reason?_____

Was your child ever in any special class(es) or did s/he receive special services? Yes_____No_____

If yes, please explain:_____

Has your child ever been suspended or expelled from school? Yes_____ No_____

If yes, please explain:_____

Does your child like school? Most of the time_____ Sometimes_____

Does your child:
Have problems making friends in school? Y/N _____

Have problems getting along with teachers? Y/N_____

Tend to get sick in the morning before school? Y/N_____

Describe teachers' concerns about your child's schoolwork or behavior (if any):

_____

_____

Has your child had any prior **psychological or neuropsychological** evaluation? Yes_____No_____