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Child's Name _____ **Date** _____

Child's Birth date _____ **Age** _____

Legal Guardian(s):

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