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**Child Name:**_____ **DOB:**_____

## REASONS FOR EVALUATION/THERAPY

**Who referred your child?** _____

**Please describe the problems, questions or concerns for which you are seeking help at this time. Also, please indicate when these problems were first noticed.**

| | **At what age were problems** |
|---|---|
| | |
| | |

**What do you think might be the reason for your child's difficulties?**

_____

## TEMPERAMENT/ CHILD'S PERSONALITY CHARACTER

Please indicate whether your child has shown any of the following behaviors. Explain, if possible.

- ☐ Excessive crying
- ☐ Talks about wanting to die
- ☐ Social withdrawal
- ☐ Destructiveness
- ☐ Ritualistic behaviors
- ☐ Anxiety, nervousness, excessive worries
- ☐ Odd thinking or speech
- ☐ Poor attention
- ☐ Fidgets / Can't sit still
- ☐ Interrupts frequently
- ☐ Peer problems
- ☐ Frequent temper tantrums
- ☐ Defiance of authority
- ☐ Delinquent behavior (e.g., lying, stealing)
- ☐ Nightmares, night terrors, sleep walking, talking in sleep
- ☐ Difficulty falling or staying asleep
- ☐ Inappropriate sexualized behaviors

Other Concerns:__ _____

_____

_____

_____

**History of mental health treatment** ☐ Yes ☐ No Inpatient treatment? ☐ Yes ☐ No
**If yes, where and when?**

_____

_____

**What was the treatment outcome?**

_____

_____

## SOCIAL HISTORY

**Mother's name**_____ **Age** _____
**Occupation**_____ **Marital status**_____
**Check which applies:** ☐ Biological/birth ☐ Adoptive ☐ Step ☐ Foster ☐ Other _____

**Father's name**_____ **Age** _____
**Occupation**_____ **Marital status**_____
**Check which applies:** ☐ Biological/birth ☐ Adoptive ☐ Step ☐ Foster ☐ Other _____

**If parents are separated or divorced, who has custody of this child?**_____

**How often does the other parent see this child? (check one)**
☐ Weekly or more often ☐ Once or twice a month ☐ Few times a year ☐ Never

**How long have the parents been separated?**_____

**With whom is child currently living (list members of household and primary caregivers)?**

| Name | Age | Relationship to patient |
|---|---|---|
| _____ | ____ | _____ |
| _____ | ____ | _____ |
| _____ | ____ | _____ |
| _____ | ____ | _____ |
| _____ | ____ | _____ |

## DEVELOPMENTAL HISTORY

### PREGNANCY HISTORY

Note: This information relates to birth (biological) parent.

**Mother's age at delivery?** _____ **Did you recevie prenatal care?** ☐ No ☐ Yes

**Mother's health during pregnancy** (check) ☐ Good ☐ Fair ☐ Poor

### BIRTH HISTORY

**Where was the child born? Name of Hospital and Location (City, State, Country)**

_____

**Length of pregnancy** _____

**Labor was** (check one) ☐ easy, no problems ☐ difficult: explain_____

**Type of delivery:** ☐ Natural (vaginal) ☐ C-section ☐ Forceps ☐ Vacuum ☐ Induced / Augmented

**Baby's position:** ☐ Head down (vertex) ☐ Legs or bottom down (breech)

**Were there any problems during labor or delivery?** ☐ Yes ☐ No

If Yes, explain:

**Birth weight:** _____ **Length:** _____ **Head circumference** _____

**Duration of mother's hospital stay** _____ **Duration of baby's hospital stay** _____

**Were there any problems while the baby was in the hospital?** ☐ Yes ☐ No
If yes; the reason(s)

Have you ever been worried that your child's development was slower than it should be? ☐ Yes ☐ No
If yes, explain:_____

Have you ever been worried that your child has lost skills that he/she used to have? ☐ Yes ☐ No
If yes, explain:_____

## SKILLS ACQUISITIONS

Please write the age at which your child did each of the following. If you cannot recall exactly, please indicate early, normal, late, or not achieved yet = NA.

| **MOTOR** | Age | Early | Normal | Late | NA | Typical Age (months) |
|---|---|---|---|---|---|---|
| Rolled over front to back | | | | | | 4-6 |
| Sat without support | | | | | | 7-8 |
| Crawled on hands and knees | | | | | | 7-8 |
| Walked with no help | | | | | | 10-15 |
| Ran well | | | | | | 21 |
| **USE OF HANDS** | | | | | | |
| Reached for object and grabbed it | | | | | | 4-5 |
| Finger fed | | | | | | 7-8 |
| Picked up small things (e.g.,Cheerios) between 2 fingers | | | | | | 12 |
| Scribbled | | | | | | 12-15 |
| | Age | Early | Normal | Late | NA | Typical Age (months) |
| Used a spoon without spilling | | | | | | 15-18 |
| Tied shoelaces | | | | | | 60-72 |
| Wrote his or her name | | | | | | 60 |
| **LANGUAGE** | | | | | | |
| Smiled Responsively | | | | | | 1-2 |
| Babbled | | | | | | 6 |
| Said “da-da” or “ma-ma” | | | | | | 8-9 |
| Understood “No” | | | | | | 8-10 |
| First word other than “mama” or “dada” | | | | | | 11-12 |
| Pointed to named picture (“Show me the dog.”) | | | | | | 18 |
| Pointed to 1 - 4 body parts | | | | | | 18-20 |
| 2 word phrases (“Let’s go”) | | | | | | 21 |
| 3 word sentences | | | | | | 36 |
| Said first and last name | | | | | | 36 |
| **SOCIAL/GENERAL SKILLS** | | | | | | |
| Laughed | | | | | | 2-4 |
| Smiled and made faces at mirror | | | | | | 4 |
| Played peek-a-boo | | | | | | 7-9 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Imitated tricks such as waving | | | | | | 9 |
| Undress self | | | | | | 36 |
| Dress self | | | | | | 48 |
| Pointed to show items of interest | | | | | | 9-14 |
| Would bring items to show you | | | | | | 14 |
| Toilet Trained: Day | | | | | | 24-36 |
| Toilet Trained: Night | | | | | | 36-48 |

## HEALTH HISTORY

**Current Weight**:_____ **Height**:_____

**Hearing**
- ☐ Ear infections
- ☐ Ear tubes
- ☐ Hearing problems

**Vision**
- ☐ Vision problems
- ☐ Wears glasses or contacts
- ☐ Eyes turning in or out

**List any PAST accidents chronic or severe medical problems your child required frequent care by a doctor or follow-up by a specialist:**

| Reason | Date | Age | Doctor / Specialist |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**List all CURRENT medical problems and medications your child is taking at this time:**

| Medical Problem | Dosage | Name of medication | Doctor/Specialist |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Has child ever had a bad reaction to a medicine?** ☐ Yes ☐ No

Explain if Yes_____

## CURRENT SKILLS

Please check the column that best describes your child compared to other children of the same age:(for school age / preschool children):

| Skill or Ability | Above Average | Average | Below Average | Not Sure |
|---|---|---|---|---|
| Throwing/catching | | | | |
| Running, jumping | | | | |
| Imaginary Play | | | | |
| Balance | | | | |
| Understanding spoken instructions | | | | |
| Expressing self verbally | | | | |
| Speaking clearly | | | | |
| Reading | | | | |
| Handwriting | | | | |

| | | | | |
|---|---|---|---|---|
| Spelling | | | | |
| Math | | | | |
| Completing homework | | | | |
| Building things | | | | |
| Self help, Dressing self | | | | |
| Tying shoes, buttoning, zipping | | | | |
| Ability to make friends | | | | |
| Ability to keep friends | | | | |

## SCHOOL HISTORY

Current School:_____ Grade:_____

Main Teacher:_____ Email:_____

Resource Room Teacher:_____ Email:_____

**What special services he/she is receiving**?_____ GPA:_____

**Has child ever been retained a grade or held back?** ☐ No ☐ Yes (explain)_____

**Has child ever been suspended**? ☐ No ☐ Yes
(explain)_____

**History of Department of Social Services (DSS) involvement**: ☐ No ☐ Yes
If Yes, explain_____

Suspect your child's drug or alcohol use? ☐ No ☐ Yes_____

Any legal problems: ☐ No ☐ Yes_____

Check any problems child has had in school in the past compared to other typical students:

| **Grade** | Unable to pay attention, stay on task, or complete assignments | Problems with learning, low or failing grades | Problems with behavior at school | Special Education or Interventions attempted by school |
|---|---|---|---|---|
| Preschool | | | | |
| Kindergarten | | | | |
| First | | | | |
| Second | | | | |
| Third | | | | |
| Fourth | | | | |
| Fifth | | | | |
| Sixth | | | | |
| Seventh-Ninth | | | | |
| Ninth-Twelfth | | | | |

## FAMILY MENTAL HEALTH/DEVELOPMEENTAL HISTORY

Does anyone in the family have any of the following? Check all that apply, past or present.

| Condition | Mother | Father | Sibling | Mother's Family | Father's Family |
|---|---|---|---|---|---|
| Learning disorder | | | | | |
| Attention problems; hyperactivity | | | | | |
| Depression/bipolar | | | | | |
| Suicide attempts | | | | | |
| Anxiety disorder/panic attacks | | | | | |
| Psychosis or schizophrenia | | | | | |
| Obsessive-compulsive disorder | | | | | |
| Alcohol or drug abuse | | | | | |
| Tics or Tourette syndrome | | | | | |
| Developmental Delays | | | | | |
| Seizures | | | | | |
| Autism | | | | | |
| Birth defects or familial disorder | | | | | |
| Cerebral palsy | | | | | |
| Speech or Language Problem | | | | | |

PARENTS' THERAPY GOALS

**What are you hoping to have happen or gain from evaluation/therapy?**

_____

_____

_____