

Crites Counseling & Consultation
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INFORMATION FROM PARENTS

Child's Name _____ Age: _____ DOB _____

M F Grade _____ Campus _____ District: _____

Information provided by _____ Relationship to Child _____

Home address: _____ Home/Cell Phone _____

A. SOCIOLOGICAL

FAMILY INFORMATION

Father/Stepfather/Guardian (CIRCLE ONE)

Full Name: _____

Occupation _____

Firm _____

Business phone _____

Cell phone _____

Mother/Stepmother/Guardian (CIRCLE ONE)

Full Name: _____

Occupation _____

Firm _____

Business phone _____

Cell phone _____

Do both natural parents live in the home? Yes No

No If no, with whom does your child live? (name) _____

Relationship to your child: _____

Does this person have written approval from the parent to care for your child? Yes No

Other children living in the home:

	Name	Age	Grade	Relationship	Learning/ Speech problems
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____

Other adults living in the home:

	Name	Age	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Have any other family members had learning or speech problems? Yes No

If yes, please explain

What language is primarily spoken in the home?

What is the language your child understands best?

What is the language your child speaks best?

What was your child's first language?

SCHOOL HISTORY

Child attended Preschool Early childhood Kindergarten

List schools your child has attended:

	School Name	Grade	Age	Learning problems
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Has your child ever:

Repeated a grade Yes No If yes, which grade(s)

Received psychological evaluation Yes No

By whom? _____ Date: _____

Received special therapy/special counseling Yes No

By whom? _____ Date: _____

Received speech therapy Yes No

By whom? _____ Date: _____

Received tutoring Yes No Subjects _____

How often? _____ Date: _____

Received special educations services Yes No If yes,

School district _____

Address _____

Dates _____

School district _____

Address _____

Dates _____

***PLEASE ATTACH A COPY OF ANY RECENT EVALUATION REPORTS

B. LANGUAGE

Please rate your child's language in relation to other children of the same AGE in each of the following areas:

1=Poor 2=Below Average 3=Average 4=Above Average 5=Superior N=Not Observed

Receptive English Language Skills

1.	Comprehends word meanings	1	2	3	4	5	N
2.	Follows oral instructions	1	2	3	4	5	N
3.	Comprehends classroom discussion	1	2	3	4	5	N
4.	Remembers information just heard	1	2	3	4	5	N

Expressive English Language Skills

1.	Uses intelligible speech	1	2	3	4	5	N
2.	Displays adequate vocabulary	1	2	3	4	5	N
3.	Speaks in complete sentences	1	2	3	4	5	N
4.	Uses adequate grammar for general understanding	1	2	3	4	5	N

5.	Expresses self fluently when called upon to speak	1	2	3	4	5	N
6.	Relates a sequence of events in order (telling a story)	1	2	3	4	5	N
7.	Organizes and relates ideas and factual information	1	2	3	4	5	N
8.	Exhibits normal vocal quality	1	2	3	4	5	N
9.	Responds appropriately with relevant information	1	2	3	4	5	N
10.	Difficulty maintaining topic of conversation	1	2	3	4	5	N

*****If there are Speech/Language concerns complete the following section:**

How does your child's speech/language problem affect his/her educational progress or performance?

Articulation of Speech Sounds:

- No concerns/no problems noted
- Unintelligible
- Difficult to understand
- Sound errors
- Reverts to "baby talk" (infantile speech)
- Does your child have (or plan to get soon) an oral appliance, braces, or other oral treatment that may affect speech?

Explain:

Language Problem:

- No concerns/no problems noted
- Has difficulty following directions
- Appears not to understand
- Responds slowly
- Speaks in single words

Voice Problem:

- No concerns/no problems noted
- Nasal quality
- Breathy quality
- Hoarse quality

Stuttering:

- No concerns/no problems noted
- Noticeable repetitions
- Speaks rapidly and repeats words
- Avoids talking

Hearing:

- No concerns/no problems noted
- Speaks in short phrases
- Under developed vocabulary
- Noticeable errors on plurals, prepositions
pronouns, verb tense, word errors
- Confused thought sequencing
- Continually talks loudly
- Speaks with low volume
- Watches speaker's mouth
- Complains of ears hurting
- Asks to have speech repeated

C. PHYSICAL

Child was born after ___ months pregnancy, weighing _____. Child was pregnancy number _____.

Pregnancy and Delivery: Normal Other _____

Compared to other children in the family, this child's development was: Slower About the same
 Faster

Comments

My child is Right handed Left handed Undetermined

List serious illnesses your child has had:

Are there any limits or precautions on your child's physical activities?

Yes No

If yes, please explain

Is your child under the care of a physician?

Yes No

If yes, please explain

Dr. _____ Date: _____

Findings:

Has your child ever had a neurological exam?

Yes No

If yes, please explain

Dr. _____ Date: _____

Findings: _

Is child taking medication?

Yes No

If yes, please explain

Do you know of any side effects the medicine might have?

Yes No

If yes, please explain

Is child on a special diet?

Yes No

If yes, please explain

Did your child ever fallen from a grocery cart, bed, changing table, etc., during infancy or early childhood? If yes, please explain what happened

Has your child ever been in a motor vehicle/motorcycle accident? If yes, please explain what happened.

Has your child ever lost consciousness after being hit in the head? If yes, please explain what happened.

Has your child ever fallen off a bike, skateboard, recreational vehicle, or fallen when playing (swing, trapeze bars, swimming, diving, etc.) and hurt his/her head? If yes, please explain what happened.

Has your child ever had stitches on the head or face? If yes, please explain what happened.

Has your child ever been knocked down and hurt while playing football, basketball, volleyball, soccer or any other sport? If yes, please explain what happened

Are there any other physical conditions a teacher/school/nurse or counselor should be aware of?

Yes **No** **If yes, please explain.**

D. EMOTIONAL/BEHAVIORAL/SOCIAL

Please circle all that apply:

Works independently	Friendly	Has friends	Generally happy
Comfortable in social situations	Shows initiative	Even-tempered	
Participates in group activities	Shows respect for others	Responsible	
Cooperative	Persistent		

*****If there are behavioral concerns, please complete the following section:**

Rate your child's behavior in relation to other children of the same AGE in each of the following areas:

Usually true to Rarely true

Attention/Distractibility/Concentration

Usually-----Sometimes-----Rarely

1.	Cannot start or finish tasks without help	1	2	3	4	5
2.	Assignments are not completed on time	1	2	3	4	5
3.	Does not listen when spoken to	1	2	3	4	5
4.	Unable to stay on task without redirection	1	2	3	4	5
5.	Easily distracted	1	2	3	4	5
6.	Daydreams	1	2	3	4	5
7.	Unusually absorbed by tasks/activities	1	2	3	4	5

Impulsivity/Activity Level

1.	Makes careless mistakes	1	2	3	4	5
2.	Does not think about consequences before acting	1	2	3	4	5
3.	Fidgets or squirms	1	2	3	4	5
4.	Has difficulty remaining seated	1	2	3	4	5
5.	Very active/on the go/restless	1	2	3	4	5
6.	Has difficulty playing quietly	1	2	3	4	5
7.	Exhibits a lack of energy/tires easily	1	2	3	4	5
8.	Talks excessively	1	2	3	4	5
9.	Blurts out answers	1	2	3	4	5
10.	Has difficulty waiting	1	2	3	4	5
11.	Interrupts or intrudes	1	2	3	4	5

Direction Following

1.	Resists taking directions from others	1	2	3	4	5
2.	Breaks rules	1	2	3	4	5
3.	Complains or refuses to do assignments/chores	1	2	3	4	5
4.	Intentionally disobeys	1	2	3	4	5
5.	Does not listen well	1	2	3	4	5

Work Related/Organization

1.	Makes poor attempts on tasks	1	2	3	4	5
2.	Dependent upon others for assistance	1	2	3	4	5
3.	Unmotivated	1	2	3	4	5
4.	Does not brings tools/materials to class	1	2	3	4	5
5.	Loses things/can't find things/ misplaces things	1	2	3	4	5
6.	Work area is disorderly	1	2	3	4	5
7.	Has difficulty organizing tasks	1	2	3	4	5
8.	Shows lack of responsibility for self/property	1	2	3	4	5

Social Acceptance

1.	Not accepted by peers	1	2	3	4	5
2.	Uncomfortable in social situations	1	2	3	4	5
3.	Poor interaction with peers	1	2	3	4	5
4.	Does not participates in group activities	1	2	3	4	5
5.	Exhibits lack of leadership qualities	1	2	3	4	5
6.	Demonstrates poor sense of humor	1	2	3	4	5
7.	Unfriendly	1	2	3	4	5
8.	Has few friends	1	2	3	4	5
9.	Argumentative	1	2	3	4	5

Aggression

1.	Threatens others verbally	1	2	3	4	5
2.	Physically aggressive toward others	1	2	3	4	5
3.	Damages property	1	2	3	4	5
4.	Overreacts to discipline	1	2	3	4	5
5.	Disrespects others and their property	1	2	3	4	5
6.	Behaviors exploit others	1	2	3	4	5

Oppositional

1.	Refuses to comply with directives	1	2	3	4	5
2.	Responds inappropriately to praise and punishment	1	2	3	4	5
3.	Uses anger to get his/her way	1	2	3	4	5

4.	Threatens others verbally	1	2	3	4	5
5	Angry when disciplined	1	2	3	4	5
6	Seems to preplan inappropriate behavior	1	2	3	4	5
7	Behavior can be quickly stopped when in trouble	1	2	3	4	5

Feelings

1.	Extremely shy/withdrawn	1	2	3	4	5
2.	Immature	1	2	3	4	5
3.	Overreacts	1	2	3	4	5
4.	Severe mood swings	1	2	3	4	5
5.	Little or no facial expressions	1	2	3	4	5
6.	Doesn't respond to emotions of others	1	2	3	4	5
7.	Diminished interest in activities/surroundings	1	2	3	4	5
8.	Feelings of hopelessness	1	2	3	4	5
9.	Unstable feelings	1	2	3	4	5
10.	Exhibits characteristics of anxiety	1	2	3	4	5
11.	Exhibits characteristics of depression	1	2	3	4	5

Somatic Complaints

1.	Loss of appetite	1	2	3	4	5
2.	Overeats	1	2	3	4	5
3.	Sleep disturbance	1	2	3	4	5
4.	Chronic stomach aches	1	2	3	4	5
5.	Chronic headaches	1	2	3	4	5
6.	Inappropriate fear reaction	1	2	3	4	5

Unusual Behaviors

1.	Difficulty with changes in routine	1	2	3	4	5
2.	Demonstrates repetitive behaviors	1	2	3	4	5
3.	Heightened sensitivity to sound/sights/textures	1	2	3	4	5
4.	Repeats words, phrases, or uses jargon	1	2	3	4	5
5.	Unusual areas/topics of interest	1	2	3	4	5
6.	Little or no eye contact	1	2	3	4	5

7. Exhibits unusual mannerisms

1 2 3 4 5

Describe the unusual mannerism, e.g., behavior or vocalization

Have there been recent changes in behavior? No Yes **If yes, explain**

Types of discipline used at home:

How often is discipline used?

Is discipline usually effective?

Who usually does the discipline?

How does the child react to discipline?

Describe any behavior(s) which is a problem to parents:

Indicate any important changes within the family during the last three years (such as job changes, moves, births, deaths, illnesses, separations, divorce.)

CHILD ACTIVITIES/INTERESTS (Check appropriate statements)

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Enjoys reading or being read to |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Likes to watch TV (How long each day?) _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Works/plays alone |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Works/plays with children his/her own age |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Works/plays with older children |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Works/plays with other children living in the home |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Works/plays with adults living in the home |

Child brings friends home Often Seldom

Child eats breakfast Always Often Seldom

What time does your child go to sleep at night and get up in the morning?

What does your child do when not in school, e.g., watch TV, read, play, part-time job, sports, scouts, music?

What activities does the family enjoy together, TV, Camping, Hobbies, Sports, Movies, Other?

Does your child have a part-time job after school or on weekends? Yes No

If yes, where does your child work?

Does your child have any responsibilities at home? Yes No If yes, explain.

Does (s)he complete them? Yes No

E. ADAPTIVE BEHAVIOR

1 = Able/Yes 2 = Not Able/Does not perform

DAILY LIVING SKILLS

- | | | | |
|----|--|---|---|
| 1. | Self care is adequate for age (personal hygiene, eating, dressing, toileting) | 1 | 2 |
| 2. | Takes care of own as well as school and other's property | 1 | 2 |
| 3. | Follows daily schedule without assistance | 1 | 2 |
| 4. | Money concepts are age appropriate | 1 | 2 |
| 5. | Time awareness is age appropriate (seasons, days, months, clock)(circle positives) | 1 | 2 |

COMMUNICATION

- | | | | |
|----|---|---|---|
| 1. | Follows oral instructions | 1 | 2 |
| 2. | Follows written instructions | 1 | 2 |
| 3. | Expresses needs clearly | 1 | 2 |
| 4. | Reads letters, simple words, age appropriate texts (circle) | 1 | 2 |
| 5. | Reads on own initiative | 1 | 2 |
| 6. | Prints/writes own name, 10 words, short notes, complete sentences (circle positives) | 1 | 2 |
| 7. | Knows personal data: <input type="checkbox"/> complete address <input type="checkbox"/> phone number <input type="checkbox"/> date of birth | 1 | 2 |
| 8. | Converses with others on age appropriate topics | 1 | 2 |

SOCIALIZATION

- | | | | |
|----|--|---|---|
| 1. | Attends school related social functions | 1 | 2 |
| 2. | Participates in group play activities (elementary) | 1 | 2 |
| 3. | Engages in appropriate "in-school" group activities without specific supervision | 1 | 2 |
| 4. | Has expressed interest in hobby or sports | 1 | 2 |

F. EDUCATIONAL

What does your child do that you consider to be very satisfactory or outstanding?

Do you feel that your child is experiencing problems in school? **Yes** **No**

What do you think the problem is?

When were you first aware of the problem?

What do you think is causing the problem?

Has your child mentioned problems with school? **Yes** **No**

How does he/she feel about the problem?

Does your child complete homework assignments? **Yes** **No**

Is there anyone at home who helps with homework? **Yes** **No**

If yes, who _____ How often? _____

Is homework a source of tension for your child? **Yes** **No**

If yes, explain

Is home work a source of tension for the parent? **Yes** **No**

If yes, explain

Child's best subject areas

Child's difficult subject areas

What has been tried at home to help with the difficult subject areas?

ADHD ISSUES

If you believe your child has had any problems with ADHD, please describe your child's history regarding (inattentive, hyperactivity/impulsivity) issues and when they first began.

Grade or Age they first began:

ADD/ADHD Characteristics that negatively affect your child's behavior or academics

OTHER IMPORTANT INFORMATION

What other things in your child's life do you believe have been causing difficulties that we should know about?

Signature(s) of Parent

Date

Please fill this form out and return to the office when you come for your first appointment!

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.