# Psychological Support Services, PLLC at The Family Enrichment Center Specializing in Developmental Disabilities 236 LePhillip Court, Suite D

##  Concord, NC 28025

704/786-4503
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BACKGROUND QUESTIONNAIRE

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_

Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Filling Out This Form: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Service(s) Requested (please check all that apply):
\_\_\_\_ Diagnostic Evaluation or other Psychological Testing \_\_\_\_ Individual Therapy
 \_\_\_\_Group Therapy \_\_\_\_ Behavior Consultation/Behavior Plan

Mother’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ Education \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ Education \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If separated or divorced, how old was the child when the separation occurred? \_\_\_\_\_\_\_\_\_

 What is the custody arrangement?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all people living in child’s household:

 Name Relationship to Child Age

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If any brothers or sisters are living outside the home, please list their names and ages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Primary language spoken in the home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **PRESENTING PROBLEM**

Please list the questions you have and/or briefly describe the current difficulties for which you are seeking help:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How long has this problem been a concern?\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What age was the child when the problem was first noticed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why do you think the problem is happening?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What seems to help the problem?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What seems to make the problem worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the child received evaluation or treatment for the current problem or a similar problem? Yes No

If yes, when and with whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Please attach copies of evaluation reports to this document

Does the child currently have a medical or mental health diagnosis? Yes No

 Please list all diagnoses given to the child by other professionals:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the child on any medications currently? If yes, please complete table below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Drug Name* | *Reason* | *Dosage* | *Started* | *Effectiveness* | *Prescribing Physician/**Psychiatrist* |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Does the child have any allergies? Please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SOCIAL AND BEHAVIOR CHECKLIST

Place a check next to any behavior or problem that your child currently exhibits:

|  |  |
| --- | --- |
| \_\_\_\_\_ Has difficulty with speech | \_\_\_\_\_ Has frequent tantrums |
| \_\_\_\_\_ Has difficulty with hearing | \_\_\_\_\_ Has frequent nightmares |
| \_\_\_\_\_ Has difficulty with language | \_\_\_\_\_ Has trouble sleeping |
| \_\_\_\_\_ Has difficulty with vision | \_\_\_\_\_ Rocks back and forth |
| \_\_\_\_\_ Has difficulty with coordination | \_\_\_\_\_Walks on toes |
| \_\_\_\_\_ Prefers to be alone  | \_\_\_\_\_Bangs head |
| \_\_\_\_\_Does not get along well with brothers and sisters | \_\_\_\_\_Problems with eating  |
| \_\_\_\_\_ Is aggressive | \_\_\_\_\_ Is stubborn |
| \_\_\_\_\_ Is shy or timid | \_\_\_\_\_Is much too active |
| \_\_\_\_\_ Is more interested in things (objects) than in people | \_\_\_\_\_ Has staring spells |
| \_\_\_\_\_ Engages in behavior that could be dangerous to self or  others (describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_Is impulsive\_\_\_\_\_ Is slow to learn\_\_\_\_\_Gives up easily |
| \_\_\_\_\_ Has special fears (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Has trouble making eye contact\_\_\_\_\_ Bites nails | \_\_\_\_\_ Has toileting problems (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  \_\_\_\_\_ Sucks thumb | \_\_\_\_\_ Routines, compulsions, obsessions (describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_Wets bed\_\_\_\_\_ Lies | \_\_\_\_\_ Other (describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ Steals\_\_\_\_\_ Hoards\_\_\_\_\_ Special skills (describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  |  |

**EDUCATIONAL HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please list **schools attended** (in order, ending with current school) | **From** (age and/or grade) | **To** (age and/or grade) | **Type of classroom** (e.g. regular education, regular education with resource, self-contained special education class) | Specialized Therapies(OT, PT, ST)in school- pls. describe type and frequency |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Has Your Child Ever Been Held Back A Grade? Yes No

If Yes, What Grade And Why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have an IEP or 504 plan? If so, please describe accommodations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place a check next to any particular educational problems your child currently exhibits:

|  |  |
| --- | --- |
| \_\_\_\_\_ Has difficulty with reading\_\_\_\_\_ Has difficulty with writing | \_\_\_\_\_ Has difficulty with other subjects (please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ Has difficulty with arithmetic | \_\_\_\_\_ Does not like school  |  |
| \_\_\_\_\_ Has difficulty with spelling |  |  |

Has Your Child Ever Received Special Tutoring Or Therapy **Outside** of School? Yes No

 If Yes, please provide dates, and describe dates, type and frequency of therapy (example: speech therapy, 30 minutes 2 times
 per week, psychologist, once per week for an hour)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **DEVELOPMENTAL HISTORY**

During pregnancy, was mother on medication? Yes No

 If so, what kind:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

During pregnancy, did mother smoke? Yes No If yes, how many cigarettes each day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

During pregnancy, did mother drink alcoholic beverages? Yes No

If yes, what and how much did she drink each day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

During pregnancy, did mother use drugs? Yes No If yes, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were forceps used during delivery? Yes No

Was a Cesarean Section performed? Yes No If yes, for what reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the child premature? Yes No If yes, by how many weeks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the child’s birth weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any birth defects or complications? Yes No If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any feeding problems? Yes No If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any sleeping problems? Yes No If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As an infant, was the child overly quiet? Yes No

As an infant, did the child like to be held? Yes No

As an infant, was the child alert? Yes No

Were there any special problems in the growth and development of the child during the first few years? Yes No

 If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was there a time in the child’s development when she or he seemed to lose skills? Yes No

 If yes, please state age and describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each

behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don’t remember

the age at which the behavior occurred, please write a question mark

|  |  |  |  |
| --- | --- | --- | --- |
| *Behavior* | *Age* | *Behavior* | *Age* |
| Responded to mother | \_\_\_\_\_\_\_\_\_\_ | Put several words together | \_\_\_\_\_\_\_\_\_\_ |
| Rolled over | \_\_\_\_\_\_\_\_\_\_ | Dressed self | \_\_\_\_\_\_\_\_\_\_ |
| Sat alone | \_\_\_\_\_\_\_\_\_\_ | Became toilet trained | \_\_\_\_\_\_\_\_\_\_ |
| Crawled | \_\_\_\_\_\_\_\_\_\_ | Stayed dry at night | \_\_\_\_\_\_\_\_\_\_ |
| Walked alone | \_\_\_\_\_\_\_\_\_\_ | Fed self | \_\_\_\_\_\_\_\_\_\_ |
| Babbled | \_\_\_\_\_\_\_\_\_\_ | Rode tricycle | \_\_\_\_\_\_\_\_\_\_ |
| Spoke first word | \_\_\_\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_\_\_\_\_ |

**MEDICAL HISTORY**

Physician’s Name and Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist Name and Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neurologist Name and Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Medical or Mental Heath Practitioner and Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Place a check next to any illness or condition that your child has had. When you check an item, also provide description where appropriate and note the approximate date (or age) of the illness

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Check* | *Illness or Condition* | *Date(s) or Age(s)* | *Check* | *Illness or Condition* | *Date(s) or Age(s)* |
| **\_\_\_\_\_\_\_** | Measles |  | **\_\_\_\_\_\_\_** | Gastrointestinal Problems |  |
| **\_\_\_\_\_\_\_** | German Measles |  | **\_\_\_\_\_\_\_** | Asthma |  |
| **\_\_\_\_\_\_\_** | Mumps |  | **\_\_\_\_\_\_\_** | Dental problems |  |
| **\_\_\_\_\_\_\_** | Chicken Pox |  | **\_\_\_\_\_\_\_** | Problems with menstrual cycle |  |
| **\_\_\_\_\_\_\_** | Whooping Cough |  | **\_\_\_\_\_\_\_** | Dizziness |  |
| **\_\_\_\_\_\_\_** | Diphtheria |  | **\_\_\_\_\_\_\_** | Frequent or severe headaches |  |
| **\_\_\_\_\_\_\_** | Scarlet fever |  | **\_\_\_\_\_\_\_** | Difficulty concentrating |  |
| **\_\_\_\_\_\_\_** | Meningitis |  | **\_\_\_\_\_\_\_** | Memory problems |  |
| **\_\_\_\_\_\_\_** | Encephalitis |  | **\_\_\_\_\_\_\_** | Extreme tiredness or weakness |  |
| **\_\_\_\_\_\_\_** | High fever |  | **\_\_\_\_\_\_\_** | Rheumatic fever |  |
| **\_\_\_\_\_\_\_** | Injuries to head |  | **\_\_\_\_\_\_\_** | Seizures |  |
| **\_\_\_\_\_\_\_** | Broken bones |  | **\_\_\_\_\_\_\_** | Tuberculosis |  |
| **\_\_\_\_\_\_\_** | Hospitalizations |  | **\_\_\_\_\_\_\_** | Anemia |  |
| **\_\_\_\_\_\_\_** | Operations |  | **\_\_\_\_\_\_\_** | Jaundice/hepatitis |  |
| **\_\_\_\_\_\_\_** | Loss of consciousness |  | **\_\_\_\_\_\_\_** | Diabetes |  |
| **\_\_\_\_\_\_\_** | Visual problems |  | **\_\_\_\_\_\_\_** | Cancer |  |
| **\_\_\_\_\_\_\_** | Allergies  |  | **\_\_\_\_\_\_\_** | High blood pressure |  |
| **\_\_\_\_\_\_\_** | Hay fever |  | **\_\_\_\_\_\_\_** | Heart Disease |  |
| **\_\_\_\_\_\_\_** | Ear problems (disease, infection, injury, or impaired hearing) |  | **\_\_\_\_\_\_\_**\_\_\_\_\_\_ | Suicide attemptOther \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**FAMILY MEDICAL AND MENTAL HEALTH HISTORY**

Place a cheek next to any illness or condition that any member of the family has had. When you check an item, please note the family member’s relationship to the child.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Check* | *Condition* | *Relationship to Child* | *Check* | *Condition* | *Relationship to Child* |
|  | Alcoholism |  |  | Autism or Asperger’s |  |
|  | Cancer |  |  | Obsessive Compulsive Disorder |  |
|  | Diabetes |  |  | Down Syndrome |  |
|  | Heart trouble |  |  | Fragile X Syndrome |  |
|  | Seizure Disorder |  |  | Anxiety Disorder |  |
|  | Intellectual Disability |  |  | Depression |  |
|  | School difficulties |  |  | Bipolar Disorder |  |
|  | Language difficulties |  |  | Suicide Attempt |  |
|  | ADHDHearing Impairment |  |  | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

# **BEHAVIORAL AND OTHER INFORMATION**

What are your child’s strengths? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What are your child’s favorite activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What are your child’s least favorite activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child ever been in trouble with the law? Yes No

 If yes, please describe briefly: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check mark next to each technique that you use:

 *Check Disciplinary Technique Check Disciplinary Technique*

 \_\_\_\_\_ Ignore problem behavior \_\_\_\_\_ Tell child to sit on chair

 \_\_\_\_\_ Scold child \_\_\_\_\_ Send child to his or her room

 \_\_\_\_\_ Spank child \_\_\_\_\_ Take away some kind of activity

 \_\_\_\_\_ Threaten child \_\_\_\_\_ Other (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_ Reason with child \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_ Redirect child's interest

Is there any other information that you think would help me work with your child or your family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\*\*Please attach copies of any previous psychological evaluation reports, behavior plans and/or behavior data if available.

Thank You!