Personal History — Children and Adolescents <18

Client's Name: ___________________________________ Today's Date: ________________________

Gender: ___ M ___ F Date of Birth: ______________ Age: _____ Grade in School: ____________

Parent(s) Name(s): ____

Address: _________________________ City: ________________ State: ________ Zip: __________

Home Phone: (____) _____________ Client's Cell (if reminder calls are desired): (_____) ____________

Any other adults approved to pick up the client besides parents:

Name: ____________________ Relationship to Child:__________________ Phone: (____) ___________

Name: ____________________ Relationship to Child:__________________ Phone: (____) ___________

Any other adults NOT approved to pick up client:

Name: ____________________ Relationship to Child:__________________ Phone: (____) ___________

Name: ____________________ Relationship to Child:__________________ Phone: (____) ___________

Primary reason(s) for seeking services:

Assessment Services

___ Cognitive Assessment
___ Academic Achievement Assessment
___ Reading Assessment
___ Math Assessment
___ Writing Assessment
___ Full Learning Assessment

Cognitive Skills Training

___ Visual Processing
___ Auditory Processing
___ Memory Skills
___ Executive Functions
___ Working Memory

Consulting

___ Homeschool Education Plan
___ Curriculum Selection
___ Classroom Planning
___ Behavior Management Plan

Test Prep

___ Elementary
___ ACT / SAT
___ GED
___ ASVAB

Academic Therapy:

___ Phonics/Spelling
___ Vocabulary/Spelling
___ Reading
___ Penmanship
___ Written Expression
___ Grammar
___ Math
___ Writing

Classes

___ Social Skills
___ Study Skills
___ Time Management
___ Essay/Research Writing
___ Algebra
___ Creative Writing
___ Public Speaking
____
____

Other — Please specify

____
____

Family History

Mother

Name: ____ Age: _____

___ Biological ___Step ___Adoptive ___Foster ___Other ______________________________

Address (if different from child's): ____

City ___________________ State _________ Zip ______________

Email: _______________________________ Mom's Cell: (____) ______________ Text? ___ Yes ___ No

Employer: __________________________ Occupation: _______________________ ___ FT ___ PT

Highest Education: ____________________ Diagnosed with Disability? _________________________

Father

Name: ____ Age: _____

___ Biological ___Step ___Adoptive ___Foster ___Other ______________________________

Address (if different from child's): _______________________ ________________________________

City _______________________ State __________ Zip ___________

Email: _______________________________ Dad's Cell: (____) ______________ Text? ___ Yes ___ No

Employer: __________________________ Occupation: _______________________ ___ FT ___ PT

Highest Education: ____________________ Diagnosed with Disability? _________________________

Siblings and Others Living in the Home

Name	Age	Grade	Gender	Any Learning Issues?
___________________________	______	______	M F	__________________
___________________________	______	______	M F	__________________
___________________________	______	______	M F	__________________
___________________________	______	______	M F	__________________
___________________________	______	______	M F	__________________
___________________________	______	______	M F	__________________

Development Information

Pregnancy and Birth

Was child born at full-term? ___ Yes ___ No If not, at how many weeks? _______

Birth weight: ________ lbs. _______ oz. Birth length: ________ in. Apgar Scores (if known): ______ / ______

Did mother smoke during pregnancy? ___ Yes ___ No

About how often? __ Once __ Seldom __ Sometimes __ Often

Did mother drink alcohol during pregnancy? ___ Yes ___ No

About how often? __ Once __ Seldom __ Sometimes __ Often

Did mother use drugs during pregnancy? ___Yes ___No If so, which one(s)? ______________________________

About how often? __ Once __ Seldom __Sometimes __ Often

Any complications during pregnancy? ____

Any complications after birth? ____

Childhood

Were there any specific issues noted from birth through age 3? ____

Were there any specific issues noted from age 4 to 12? ____

Did you child hit most developmental milestones: Later than usual About on time Earlier than usual

Is your child often: (Please circle all that apply.)

Happy? Grumpy? Fussy? Easy-going? Uncooperative? Helpful? Angry? Talkative? Moving? Sleepy?

Frustrated? Nervous? Quiet? Loud? Stubborn? Tired? Fidgety? Creative? Asking Questions? Forgetful?

Any history of:

___ physical/sexual abuse? ___ inadequate nutrition ___ emotional/verbal abuse
___ neglect ___ growth issues ___ moving houses or to another state
___ homelessness ___ foster care ___ social issues
___ genetic/birth disorder ______________________ ___ injuries ___________________________________

Adolescence

Do you and your teenager have a good relationship? ___ Yes ___ No Is your teen trustworthy? ___ Yes ____ No

About what age did your teen hit puberty? ___________ Does your teenager have friends? ___ Yes ___ No

Are there any specific development issues to note from age 11 to 18?

____
Are there any special, unusual, or traumatic circumstances that affect your adolescence? ___ Yes ___ No
If yes, please describe ____
Adolescent social/personal issues: ___ Physical Abuse ___ Sexual Abuse ___ Verbal Abuse ___ Neglect ___ Food Issues
___ Bullying ___ Other ________________________ In any of these was your teen the: ___ Victim ___ Perpetrator
Was your teen ever a foster child? ___ Yes ___ No If yes, when? ______________________
Was your teen adopted? ___ Yes ___ No If yes, when? ______________________ **What age?**
Any additional information about your child's teen years you would like us to know about?:

____

Education Information

Current school: ____ Grade: ___________
Type of school: ___ Public ___ Charter ___ Private ___ Homeschool Out of state? ___ Yes ___ No
Typical grades or GPA? ________ Recent changes in report card grades? ___ Yes ___ No
Ever retained? ___ Yes ___ No Which grade? ______
In special education? ___ Yes ___ No Active IEP? ___ Yes ___ No 504 Plan? ___ Yes ___ No
Previous diagnostic assessment? ___ Yes ___ No Date of assessment: _____________________
Who administered the assessment? ____ School Psychologist ___ Private Provider _________________
Diagnostic Label(s) ____
In gifted program? ___ Yes ___ No Ever skipped a grade? ___ Yes ___ No Which grade? ___________
Ever changed schools? ___ Yes ___ No For what reason(s): _____________________________________

What are your child's strengths? ____
What are your child's weaknesses? ____

What is YOUR opinion of your child's performance in the following subjects?

Reading: ___ Far below grade level ___ Somewhat below grade level ___ At grade level ___Somewhat above grade level ___ Far above grade level

Spelling: ___ Far below grade level ___ Somewhat below grade level ___ At grade level ___Somewhat above grade level ___ Far above grade level

Writing: ___ Far below grade level ___ Somewhat below grade level ___ At grade level ___Somewhat above grade level ___ Far above grade level

Math: ___ Far below grade level ___ Somewhat below grade level ___ At grade level ___ Somewhat above grade level ___ Far above grade level

Soc Stud: ___ Far below grade level ___ Somewhat below grade level ___ At grade level ___ Somewhat above grade level ___ Far above grade level

Science: ___ Far below grade level ___ Somewhat below grade level ___ At grade level ___Somewhat above grade level ___ Far above grade level

What are your child's interests, hobbies, or leisure activities?
____
Does your child exercise? ___ Yes ___ No What does your child do for physical exercise?
____
Does your child play an instrument or sing? ___ Yes ___ No What does your child play?
____
Does your use: Touchscreens? A mouse? A touchpad? A video game controller? A trackball?
Does your child use a computer? ___ Yes ___ No What system(s) do you prefer?
____
Does your child play video games? ___ Yes ___ No What system(s) has your child played?
____

What are YOUR primary goals for your child's training?
____
____

Education Information (cont'd)

Feelings about school

___ Angry
___ Fearful
___ Anxious
___ Bored
___ Ambivalent (Neutral)
___ Other ____________________
___ Confident
___ Eager
___ Enthusiastic

Approach to School Work

___ Refuses
___ Disorganized
___ No initiative
___ Sloppy
___ Incomplete assignments
___ Does only what is expected
___ Cooperative
___ Organized
___ Independent
___ Goes above and beyond
___ Other ________________________
____

Peer Relationships

___ Difficulty making friends
___ Makes friends easily
___ Extraverted
___ Has many friends
___ Socially confident
___ Leader
___ Follower
___ Introverted
___ Has a few friends
___ Socially awkward
___ Accepted by peers
___ Experienced rejection
___ Social anxiety
___ Has long-term, very close friends

Emotional / Behavioral Patterns

___ Affectionate
___ Aggressive
___ Always moving
___ Angry
___ Anxious
___ Avoids
___ Clumsy
___ Confused easily
___ Cooperative
___ Daydreams
___ Defiant / Talks back
___ Depressed
___ Difficulty speaking
___ Expects failure
___ Fatigues easily
___ Friendly
___ Frustrated easily
___ Generous
___ Happy / Cheerful
___ Helpful
___ Hypervigilant
___ Impulsive
___ Inattentive
___ Lies
___ Overly messy
___ Overly neat
___ Obsesses or Perseverates
___ Perfectionistic
___ Submissive
___ Talks excessively
___ Tics or Twitching
___ Other _______________________

Health and Learning Issues

Does your child have any of the following health or learning conditions?

___ Allergies
___ Anxiety
___ Aphasia
___ Apraxia
___ Asthma
___ Attention Deficit/Hyperactivity
___ Autism Spectrum Disorder
___ Blindness
___ Central Auditory Processing Disorder
___ Cerebral Palsy
___ Cleft lip/palate
___ Deafness
___ Developmental Disorder
___ Diabetes
___ Dyslexia
___ Emotional Disorder
___ Glandular Problems
___ Mental Illness ________________
___ Migraines
___ Hypotonia
___ Perceptual Motor Disorder
___ Seizures
___ Other ___________________

How is the overall health of your child? ___ Excellent ___ Very Good ___ Good ___ Fair ____ Poor

Is your child current on immunizations? ___ Yes ___ No ___ Conscientious objector

Does your child have any sleep problems? ___ Yes ___ No If yes, describe ____

Has your child had a recent eye exam for acuity? ___ Yes ___ No Results? _______________________________________

Glasses? ___ Yes ___ No Contacts? ___ Yes ___ No

Has your child ever received vision therapy? ___ Yes ___ No

Has your child had a recent hearing exam? ___ Yes ___ No Results? ____

Hearing aids? ___ Yes ___ No Surgery? ___ Yes ___ No If yes, describe _______________________________________

Has your child ever received speech/language therapy? ___ Yes ___ No Reason? _________________________________

Has your child ever received counseling services, including play therapy? ___ Yes ___ No Reason? ____________________

Has your child ever received tutoring services or academic interventions at school (RTI, Title I, etc)? ___ Yes ___ No

Is your child currently on any prescribed or over-the-counter medications? ___ Yes ___ No

If yes, please list medications (including OTC, dose, and condition):

____

____

Does your child use or have a problem with smoking or vaping? ___ Yes ___ No Describe if needed ______________________

Does your child use or have a problem with drinking alcohol? ___ Yes ___ No Describe if needed ________________________

Does your child use or have a problem with drugs, including marijuana? ___ Yes ___ No Describe if needed _______________

Does your child use or have a problem with any other chemical substance? ___ Yes ___ No Describe if needed _____________

Does your teen drive a vehicle? ___ Yes ___ No If no, reason ____

Cultural / Spiritual Information

Are there any cultural or ethnic issues we should be sensitive to? ____

Are you affiliated with a spiritual or religious group? ___ Yes ___ No If yes, describe ___________________________________

Would you like cultural or spiritual beliefs incorporated into your cognitive or academic training? ___ Yes ___ No

If yes, what or how? ____

NOTE: If you are unsure at this time, feel free to let us know your preferences as your training progresses.

Parent Responsibilities

Who handles responsibilities for:

School communication or Instruction: ___ Mother ___ Father ___ Shared ___ Other ___________________________

Homework: ___ Mother ___ Father ___ Shared ___ Other ___________________________

Health: ___ Mother ___ Father ___ Shared ___ Other ___________________________

Behavior Problems: ___ Mother ___ Father ___ Shared ___ Other ___________________________

If the client is a teenager, is the client employed at a job? ___ Yes ___ No

Employer __________________________ Position ______________________________ Hours per Week ________________

Will work impact training time? ___ Yes ___ No Will the client be driving to appointments alone? ___ Yes ___ No

NOTE: You are welcome to wait while your child is training. If your child is dropped off, and we are unfamiliar with a anyone, including a parent, we will ask for photo identification to match to your request to assure the safety of your child.

Please ask your child to draw a picture of him or herself here. The picture can also be drawn on paper and attach it with this form.

Policies

Attendance and Cancellations. Brighter Path wants to respect the time and needs of all of our clients, and we desire to provide the highest quality of educational services for your child. Therefore, it is important that you arrive on time or a bit early for all scheduled appointments. In cases where clients are late for scheduled appointments, the appointment will end at the scheduled time regardless of the remaining time. If you need to cancel, please call at least 24 hours in advance. Short notice may result in a partial fee for a scheduled appointment. No shows will be billed at the regular rate since we will not be able to fill that spot with other clients who may have needed that time. Drop-In cognitive training will count toward the program allotment, but requires no appointment. Drop-in training is available on a first-come, first-serve basis.

____ ____________________________

Parent/Guardian Signature Today's Date

Confidentiality. I acknowledge that the information provided is accurate. Brighter Path holds to the highest professional ethics in both the education and psychology fields. I understand the information will be used only by the center staff for assessing, determining an appropriate cognitive and/or academic program, and implementing services. I can obtain copies of my child's report at any time. The information will be kept confidential and released to other providers only with a written release of information form.

____ ____________________________

Parent/Guardian Signature Today's Date

Process and Financial Commitment.

An assessment for cognitive skills, academic skills, or both will be conducted with your child unless a previous diagnostic assessment is submitted. Following the assessment, the results will be reported, and a program designed specifically for your child will be presented. You are under no obligation to continue with our services. If your child joins us for training, the training commitment will be 50 hours, extending in 10 hour increments as needed. You may still withdraw at any time.

Payment for the assessment will be required at the time of service. Down payment for therapy programs are due up front and are non-refundable. The balance may be divided over the course of training. A statement will be emailed at the beginning of each month. Fees for cognitive training must be paid in full prior to starting continuation or other services. Payments accepted are credit cards, debit cards, checks, and cash. Arizona ESA funds may also be used for our services.

Who is responsible for payment? Name: ____

Relationship to Child: ____

Address ___________________________ City ______________ State _______ Zip ____________

Email: _________________________________ Phone: (____) ________________ Text? ___ Yes ___ No

____ ____________________________

Parent/Guardian Signature Today's Date