

## Personal History — Children and Adolescents <18

Client's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Gender: \_\_\_ M \_\_\_ F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade in School: \_\_\_\_\_

Teen's Cell (if available) (\_\_\_\_\_) \_\_\_\_\_ Text? \_\_\_ Yes \_\_\_ No

Teen's Email (if available): \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Primary reason(s) for seeking services:

#### **Mother**

Name: \_\_\_\_\_

\_\_\_ Biological \_\_\_ Step \_\_\_ Adoptive \_\_\_ Foster \_\_\_ Other \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mom's Email: \_\_\_\_\_ Mom's Cell: (\_\_\_\_) \_\_\_\_\_ Text? \_\_\_ Yes \_\_\_ No

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ \_\_\_ FT \_\_\_ PT

Highest Education: \_\_\_\_\_ Diagnosed with Disability? \_\_\_\_\_

#### **Father**

Name: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Dad's 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	_____

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

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

#### **Any other adults NOT approved to pick up client:**

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

## 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? \_\_\_\_\_ Extra help?  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?

	2+ yrs below grade level	@ 1 yr below grade level	At grade level	@ 1 yr above grade level	2+ yrs above grade level
Reading:	_____	_____	_____	_____	_____
Spelling:	_____	_____	_____	_____	_____
Writing:	_____	_____	_____	_____	_____
Math:	_____	_____	_____	_____	_____
Soc Stud:	_____	_____	_____	_____	_____
Science:	_____	_____	_____	_____	_____

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 child use:  Touchscreen?  Mouse?  Touchpad?  Game controller?  Tackball?

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

- |                                  |   |                                       |
|----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Angry   | <input type="checkbox"/> Bored                | <input type="checkbox"/> Confident    |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Ambivalent (Neutral) | <input type="checkbox"/> Eager        |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Other _____          | <input type="checkbox"/> Enthusiastic |

### Approach to School Work

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Refuses       | <input type="checkbox"/> Incomplete assignments     | <input type="checkbox"/> Independent           |
| <input type="checkbox"/> Disorganized  | <input type="checkbox"/> Does only what is expected | <input type="checkbox"/> Goes above and beyond |
| <input type="checkbox"/> No initiative | <input type="checkbox"/> Cooperative                | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Sloppy        | <input type="checkbox"/> Organized                  | _____  |

### Peer Relationships

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Difficulty making friends | <input type="checkbox"/> Leader            | <input type="checkbox"/> Accepted by peers                 |
| <input type="checkbox"/> Makes friends easily      | <input type="checkbox"/> Follower          | <input type="checkbox"/> Experienced rejection             |
| <input type="checkbox"/> Extraverted               | <input type="checkbox"/> Introverted       | <input type="checkbox"/> Social anxiety                    |
| <input type="checkbox"/> Has many friends          | <input type="checkbox"/> Has a few friends | <input type="checkbox"/> Has long-term, very close friends |
| <input type="checkbox"/> Socially confident        | <input type="checkbox"/> Socially awkward  |  |

### Emotional / Behavioral Patterns

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Affectionate         | <input type="checkbox"/> Depressed           | <input type="checkbox"/> Inattentive              |
| <input type="checkbox"/> Aggressive           | <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Lies                     |
| <input type="checkbox"/> Always moving        | <input type="checkbox"/> Expects failure     | <input type="checkbox"/> Overly messy             |
| <input type="checkbox"/> Angry                | <input type="checkbox"/> Fatigues easily     | <input type="checkbox"/> Overly neat              |
| <input type="checkbox"/> Anxious              | <input type="checkbox"/> Friendly            | <input type="checkbox"/> Obsesses or Perseverates |
| <input type="checkbox"/> Avoids               | <input type="checkbox"/> Frustrated easily   | <input type="checkbox"/> Perfectionistic          |
| <input type="checkbox"/> Clumsy               | <input type="checkbox"/> Generous            | <input type="checkbox"/> Submissive               |
| <input type="checkbox"/> Confused easily      | <input type="checkbox"/> Happy / Cheerful    | <input type="checkbox"/> Talks excessively        |
| <input type="checkbox"/> Cooperative          | <input type="checkbox"/> Helpful             | <input type="checkbox"/> Tics or Twitching        |
| <input type="checkbox"/> Daydreams            | <input type="checkbox"/> Hypervigilant       | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> Defiant / Talks back | <input type="checkbox"/> Impulsive           |   |

## Health and Learning Issues

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

- |   |  |
|---|--|
| <input type="checkbox"/> Allergies                            | <input type="checkbox"/> Developmental Disorder    |
| <input type="checkbox"/> Anxiety                              | <input type="checkbox"/> Diabetes                  |
| <input type="checkbox"/> Aphasia                              | <input type="checkbox"/> Dyslexia                  |
| <input type="checkbox"/> Apraxia                              | <input type="checkbox"/> Emotional Disorder        |
| <input type="checkbox"/> Asthma                               | <input type="checkbox"/> Glandular Problems        |
| <input type="checkbox"/> Attention Deficit/Hyperactivity      | <input type="checkbox"/> Mental Illness _____      |
| <input type="checkbox"/> Autism Spectrum Disorder             | <input type="checkbox"/> Migraines                 |
| <input type="checkbox"/> Blindness                            | <input type="checkbox"/> Hypotonia                 |
| <input type="checkbox"/> Central Auditory Processing Disorder | <input type="checkbox"/> Perceptual Motor Disorder |
| <input type="checkbox"/> Cerebral Palsy                       | <input type="checkbox"/> Seizures                  |
| <input type="checkbox"/> Cleft lip/palate                     | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Deafness                             |  |

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

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):

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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

Does your child use or have a problem with any other chemical substance?  Yes  No

Does your teen drive a vehicle?  Yes  No

Has your child ever been suspended or expelled from a school?  Yes  No

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

If your child is 10 years old or under, 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.

### 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/school impact training time? \_\_\_ Yes \_\_\_ No

Would you like time management training for your teen? \_\_\_ 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, we will only release your child to an approved adult named on this form and will ask them for photo identification.

## 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. Although we have a membership program and you can cancel at any time, we encourage a personal commitment of a minimum of 4 months or 50 play days to see the benefits of training as shown in current research.

The Brighter Path membership involves a Path Finder fee of \$189 for the first month that includes an assessment or review of outside assessments, program matching, license fees, and the first month of training. The on-going membership is \$89 per month. We can set up an automatic payment with your approval. Otherwise, we do not keep credit card information on file. Payment for each month is due up front based on the start date.

Who is responsible for payment? Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Text?  Yes  No

Do you want an automatic payment set up?  Yes  No

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Today's Date