The Brain Center

Psychological Services

5605 Princeton Avenue

Columbus, Ga. 31904

It is extremely important that this form is completed thoroughly and accurately since the information provided below will be used in the completion of the psychological report !!!

Name of Patient: Date of Birth: Age:

Biological mother's name: Date of Birth:

Biological mother's occupation:

Biological father's name: Date of Birth:

Biological father's occupation:

Biological parents' marital status: Married Separated Divorced Cohabiting Widowed

Who has custody of the patient:

Name of legal guardian (if different from biological parent):

Circle one that applies: Adoptive parent Foster parent Legal guardian

If patient is not with biological parents, please give time and reason for separation:

Time: Reason:

Please, list all people who live in the household and their relationship with the patient (include parents):

Is there a history of child abuse: Yes No

If yes, what type of abuse:

Were child protective services involved: Yes No

Are they still involved: Yes No

School/Daycare

Name of school or daycare the patient attends:

Grade level: Repeated grade: Yes No If yes, what grade:

Is the patient receiving any special educational services at school:

If yes, what type of services:

Pregnancy/Birth History

Length of pregnancy: Child's birth weight:

Vaginal bleeding: Yes No

Preeclampsia: Yes No

Serious illness or injury: Yes No If yes, explain:

Prescription medication during pregnancy: Yes No

Illegal drug use during pregnancy: Yes No

Smoked cigarettes during pregnancy: Yes No

Any other problems during pregnancy:

Delivery was induced: Yes No

Cesarean-section delivery: Yes No

Any other problems during delivery:

Was child injured during delivery: Yes No

Was child placed in the Neonatal Intensive Care Unit Yes No

If yes, how long was child in the NICU:

Developmental history

Please indicate the age your child first accomplished the following: (indicate in months)

Sitting Independently:

Crawling:

Walking without assistance:

Babbling:

Saying single words:

Saying two-three words sentences:

Asking questions:

Back-and-forth conversation with others:

Bladder training during the day:

Bowel training during the day:

Bladder training during the night:

Bowel training during the night:

Child's health history

Does your child have any of the following:

Asthma Yes No

Allergies Yes No

Seizures Yes No If yes, date of seizures:

Heart condition Yes No

Head injury with concussion Yes No

Hearing difficulties Yes No If yes, what type:

Vision difficulties Yes No If yes, what type:

Any genetic condition Yes No

Any other health conditions:

History of hospitalizations:

History of surgeries:

List any medications your child is taking (name, dosage, starting date and name of prescribing doctor)

Psychiatric History

Has your child ever had a psychiatric exam: Yes No

If yes, please provide date, diagnosis and name of doctor:

Has your child ever had a psychological exam: Yes No

If yes, please provide date, diagnosis and name of doctor:

Has your child ever received therapy/counseling Yes No

Does your child currently receiving therapy/counseling Yes No

Place and frequency of therapeutic services:

Does your child receive speech therapy Yes No

If yes, name of facility, frequency of therapy and start date:

Does your child receive occupational/physical therapy Yes No

If yes, name of facility, frequency of therapy and start date:

Please, describe your child's current level of language skills (does your child babble, uses words, uses sentences or asks questions). How does your child indicate his/her needs?

Please, describe your child's social interest/functioning (does your child interested in other children, plays cooperative, shares toys, plays cooperatively, etc.)

Does your child engage in any repetitive behaviors?

Does your child have any strong interests, fixation or obsessions with certain toys, activities, television shows or characters?

Does your child have any temper tantrums or emotional meltdowns? Please, describe any triggers, specific behaviors and length of tantrums.

Please, indicate any additional concerns/observation of your child:

____ ____________________

Signature of the person completing this form Date