THE BRAIN CENTER

Psychological Services

Columbus, GA.

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

Name of Patient:	
Date of Birth:	Age:
Biological Mother's name:	Date of Birth:
Mother's occupation:	
Biological Father's name:	Date of Birth:
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, time and reason for separation: Time:	
List people who live in the household and their relationship with the patient:	
Is there a history of child abuse? Yes No If yes, what type of abuse? Verbal Physical Sexual Emotional	

Were child protective services involved?	Yes	No		
Are they still involved?	Yes	No		
Name of the school the patient attends:				
Grade Level: If yes, which grade was repeated?	Has the patient repeated a grade?		Yes	No
Is the patient receiving any special services at school?	Yes	No		
If yes, what type of services?				
Did any of the following conditions occur during pregnancy/delivery?				
Vaginal Bleeding	Yes	No		
Preeclampsia	Yes	No		
Rh Factor Incompatibility	Yes	No		
Serious illness or injury	Yes	No		
If yes, what type of illness and injury?				
Took prescription medication	Yes	No		
If yes, name of medication:				
Took illegal drugs	Yes	No		
Smoked cigarettes	Yes	No		
Please, describe any other problems with pregnancy				
Delivery was induced	Yes	No		
Cesarean-section delivery	Yes	No		
Please describe any other problems with delivery				
Did any of the following conditions have occurred after delivery?				
Injured during delivery	Yes	No		

Cardiopulmonary distress during delivery	Yes	No
Respiratory distress following delivery	Yes	No
Needed Oxygen	Yes	No
Had an infection	Yes	No
Was placed in the NICU (Neonatal Intensive Care Unit) If yes, how long did the patient remain in NICU?	Yes	No
At what age did your child first accomplish the following? (indicate in months)		
Sitting Independently		
Crawling		
Walking without any assistance		
Babbling		
Saying single words		
Saying two, three word sentences		
Asking questions		
Back-and-forth conversation with others		
Understanding verbal instructions		
Bladder training during day		
Bladder training at night		
Bowel training during day		
Bowel training at night		
Health history		
Name of Pediatrician:		
Phone number of Pediatrician:		

Current Medications:		
Current Allergies:		
Does your child has any of the following?		
Asthma	Yes	No
Allergies	Yes	No
Seizures If yes, list the dates of the seizures	Yes	No
Heart condition	Yes	No
Head injury with concussion	Yes	No
Hearing difficulties If yes, what type	Yes	No
Vision difficulties If yes, what type	Yes	No
Fine motor/handwriting problems	Yes	No
Gross motor problems/balancing issues	Yes	No
Appetite problems If yes, what type	Yes	No
Sleep Problems If yes, what type	Yes	No
Ongoing toileting accidents If yes, please specify	Yes	No
Any genetic conditions If yes, please specify	Yes	No
Any other health difficulties (please describe)		

History of hospitalizations (please describe)		
History of surgeries (include dates, procedures)		
Please list all current medications (name, dosage, starting date, name of prescribing doctor)		
Past Psychiatric History		
Has the child ever had any psychiatric exam If yes, date, outcome and name of doctor	Yes	No
Has the child ever had any psychological testing If yes, date, results and name of doctor	Yes	No
Has the child ever received therapy/counseling If yes, date, what type of therapy, name of provider	Yes	No
Does your child currently receives any of these: Speech therapy If yes, name of facility, frequency of therapy and start date	Yes	No

Occupational therapy	Yes	No
If yes, name of facility, frequency of therapy and start date		

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

Describe your child's social interest/functioning (is your child interested in others, plays cooperatively, has best friends, shares toys, etc.)

Describe any repetitive behaviors you have observed of your child

Does your child have any strong interest, fixation or obsessions with certain toys, activities, TV shows or characters? If yes, please give detailed description

Describe your child's sensory reactions-how do they respond to the following: loud noises, strong odors, picky eating, clothes/shoes/socks, haircuts, dental work etc.

Does your child have any temper tantrums or emotional meltdowns?

If yeas, pleased describe triggers, specific behaviors and length of meltdowns.

Please, indicate any additional concerns/observation of your child

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Signature of the Person Completing this form Date