

ACAPS



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Patient Questionnaire & History *Child & Adolescent Form*

Please print clearly & complete as thoroughly as possible.

Today's Date: _____

Name of person completing this form: _____

Please list relationship to Patient: _____

Patient Demographics

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ Date of Birth: _____ Age: _____

Biological Sex: Male / Female Gender Identity: Male / Female / Other: _____

Street/Mailing Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Child/Adolescent has lived at this address since: _____

Home Phone#: _____ Cell Phone#: _____

Is English the patient's first/primary language? Yes / No If no, please list primary language: _____

Referral Source Information

Who referred patient to ACAPS for this evaluation? _____

Street Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Phone#: _____ Fax#: _____

Primary reason for referral: _____

Medical Diagnosis (if applicable): _____

Family Information

Was the child adopted? Yes / No If yes, what type of adoption? _____

Approximate date child was adopted: _____ Age of child when s/he was adopted: _____

Who has custody? (*circle one*): *Mother and Father / Split custody / Mother only / Father only / Mother and significant other / Father and significant other / Legal guardian / Other:* _____

If custody is divided, how much time is spent with each parent/caregiver?

Caregiver(s) that child spends the majority of the week living with (include Name(s) and Relation(s) to child):

Number of sibling(s) patient has (Total): _____

Biological _____ # Half Sibling _____ # Other (*please specify*) _____

Additional people who live with the child, and their relations to the child:

Are there any current or pending legal or custody cases at this time? Yes / No

If yes, please explain: _____

Is there currently any significant discord between family members? Yes / No

If yes, who is involved? _____

Is there family stress around transportation? Yes / No

Is there family stress around finances? Yes / No

Additional Comments (if applicable) : _____

Parent Information

Mother's Full Name: _____

Mother's Phone #(s): _____ Occupation: _____

Email(s): _____

Highest level of education completed: _____ Marital Status: *Married / In a relationship / Single Other:* _____

Mother's Address if different than child's:

Mailing Address: _____

City: _____ State: _____ Zip/Postal Code: _____

If the mother is not married to the father:

Mother's Significant Other's Name: _____

Phone #(s): _____ Occupation: _____

Highest level of education completed: _____

Father's Full Name: _____

Father's Phone #(s): _____ Occupation: _____

Email(s): _____

Highest level of education completed: _____ Marital Status: *Married / In a relationship / Single*
Other: _____

Father's Address if different than child's:

Mailing Address: _____

City: _____ State: _____ Zip/Postal Code: _____

If the father is not married to the mother:

Father's Significant Other's Name: _____

Phone #(s): _____ Occupation: _____

Highest level of education completed: _____

***If there is a legal guardian:** (Please note that **guardianship documents must be provided** along with this form):

Guardian's Name: _____

When was guardianship established?: _____ Type of Guardianship: _____

Are there plans to terminate guardianship? _____

Phone Number: _____ Occupation: _____

Email (s): _____

Mailing Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Biological Parents' Medical History

Please check all items that apply for the **biological parents:**

Biological Mother:

- Alcoholism
- Anxiety
- Attention/Concentration problems
- Depression
- Drug abuse
- Hyperactivity
- Learning problems
- Moodiness
- Obsessive Compulsive Disorder
- Psychiatric hospitalization
- School problems

Biological Father:

- Alcoholism
- Anxiety
- Attention/Concentration problems
- Depression
- Drug abuse
- Hyperactivity
- Learning problems
- Moodiness
- Obsessive Compulsive Disorder
- Psychiatric hospitalization
- School problems

___Speech-Language Disorders
___Suicide
___Unreasonable fears (phobias)
___Other: _____

___Speech-Language Disorders
___Suicide
___Unreasonable fears (phobias)
___Other: _____

Additional Comments:

Pregnancy and Delivery

Duration of pregnancy (in weeks)_____ (e.g. full term = 40 weeks)

Type of labor: *Spontaneous / Induced* Duration (Hours: _____)

Type of delivery: *Vaginal / C-section*

Birth weight_____lbs _____oz

Please check all of the following problems that **occurred during the pregnancy**:

- | | |
|---------------------------------------|--|
| ___Anemia | ___Toxemia |
| ___Diabetes | ___Toxic exposure |
| ___Excessive vomiting | ___Trauma (physical/mental) |
| ___High blood pressure (hypertension) | ___X-rays during pregnancy |
| ___Infections | ___Alcohol Consumption - If so, amount
& frequency ? _____ |
| ___Physical Injury | ___Substance use ? - If so, what type(s), amount, &
frequency ? _____ |
| ___RH incompatibility | ___Smoking - If so, how many & how often ? |
| ___Spotting/bleeding | ___Other (please explain): _____ |
| ___Threatened miscarriage | |

Surgeries during pregnancy ? Yes / No

If so, please specify type and reason: _____

Other illnesses during pregnancy: _____

Medications and supplements taken during pregnancy: _____

Other significant events, complications, or diagnostic procedures: _____

Please check all complications that **occurred during the delivery or immediately after:**

- | | | |
|--|---|--|
| <input type="checkbox"/> Birth injury | <input type="checkbox"/> Jaundiced | Required transfusions |
| <input type="checkbox"/> Breech presentation | <input type="checkbox"/> Meconium Aspiration Syndrome (MAS) | <input type="checkbox"/> Sepsis/Infection |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Oxygen deprivation | <input type="checkbox"/> Use of forceps |
| <input type="checkbox"/> Cord around neck | | <input type="checkbox"/> Vacuum extraction |
| <input type="checkbox"/> Hemorrhage | | |

If you answered yes to any of the above complications, please explain the issue **and** the treatment that was needed: _____

Other complications? (If so, please explain): _____

Following delivery, please provide total number of days child spent in hospital = _____

If child was admitted to neonatal intensive care unit (NICU) or if s/he required an Incubator: How many days did child spend in NICU /Incubator ? = _____

APGAR Scores (if known)=_____

Please check any and all complications that **occurred birth to 6 months**:

- | | | |
|--|--|--|
| <input type="checkbox"/> Problems sucking | <input type="checkbox"/> Problems growing | <input type="checkbox"/> Excessive sleep |
| <input type="checkbox"/> Problems swallowing | <input type="checkbox"/> Unusual stiffness | <input type="checkbox"/> Milk allergies |
| <input type="checkbox"/> Feeding problems | <input type="checkbox"/> Problems sleeping | <input type="checkbox"/> Other allergies |
| <input type="checkbox"/> Problems breathing | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> RH factor problem |
| <input type="checkbox"/> Seizures | | |

Other complications? (If so, please explain): _____

Child's Medical History

Primary care doctor: _____ Office name: _____

Office#: _____ Fax#: _____

Please indicate if your child has received any of the following:

CT Scan, if yes, date: _____

- ___fMRI, if yes, date: _____
- ___MRI, if yes, date: _____
- ___SPECT, if yes, date: _____
- ___PET, if yes, date: _____
- ___EEG, if yes, date: _____
- ___EKG, if yes, date: _____
- ___MEG, if yes, date: _____
- ___Spinal tap, if yes, date: _____

Please list **Medications and/or Supplements** that your child is currently taking to address medical concerns including **Dose** and **Reason for Medication**.

<u>Medication:</u>	<u>Dosage:</u>	<u>Reason for Medication:</u>
--------------------	----------------	-------------------------------

1. _____
2. _____
3. _____
4. _____

Do you currently have any concerns about your child’s ability to see? Yes / No

When was the last time you had your child’s vision tested? Date: _____

Does your child use/require glasses or contact lenses? Yes / No

Do you currently have any concerns about your child’s ability to hear? Yes / No

When was the last time you had your child’s hearing tested? Date: _____

Has your child ever had pressure equalization tubes placed? Yes / No If so, at what age(s)? _____

Does your child use/require hearing aids? Yes / No

Does your child have a history of seizures? Yes / No If yes: With fever / Without fever

Frequency: _____ Causes: _____

Has your child ever been hospitalized for medical reasons? Yes / No If yes, please provide more details about the reason(s) and the date(s) of occurrence : _____

Has your child ever had any surgeries? Yes / No If yes, please provide the reason(s) and the date(s) of occurrence: _____

Has your child ever had any serious head/brain/spinal cord injury/ies? Yes / No

If yes, please provide more details about what happened and the date(s) of occurrence: _____

Has your child ever lost consciousness? Yes / No If yes, please provide the context and duration: _____

Does your child have any known allergies or sensitivities? Yes / No If yes, please specify: _____

Please check all of the following health problems that your child has had and/or is currently experiencing (past, present) and list **age(s) of occurrence**. Please mark “C” for current.

- | | | |
|--|--|--|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Pallor |
| <input type="checkbox"/> Abnormal gait | <input type="checkbox"/> Excessive weight gain | <input type="checkbox"/> Palpitation of the heart |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Persistent cough |
| <input type="checkbox"/> Chronic diarrhea | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Chronic vomiting | <input type="checkbox"/> Head injury | <input type="checkbox"/> Prominent eyes |
| <input type="checkbox"/> Cold, mottled skin | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Puffy eyelids |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hoarse cry | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Coarse, dry hair | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sluggishness (lethargy) |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Itching of skin | <input type="checkbox"/> Stretch marks on skin |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Joint or bone pains | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Dry, scaly skin | <input type="checkbox"/> Large tongue | <input type="checkbox"/> Un-coordination |
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Lump in neck | <input type="checkbox"/> Urinary frequency/urgency |
| <input type="checkbox"/> Excessive body hair | <input type="checkbox"/> Nausea | <input type="checkbox"/> Visual difficulty |
| <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Weakness |
| | | <input type="checkbox"/> Weight loss |

Please check any and all of the following illnesses or conditions that your child has experienced and age(s) of occurrence. Please mark “C” for current.

- | | | |
|--|---|---|
| <input type="checkbox"/> Adrenal gland disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> AIDS/HIV positive | <input type="checkbox"/> Dizziness (e.g. vertigo) | <input type="checkbox"/> Macular degeneration |
| <input type="checkbox"/> Amputations | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Endocrine problems | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Movement disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Blood disease (e.g. anemia) | <input type="checkbox"/> Gastro esophageal reflux | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Bowl or bladder incontinence | <input type="checkbox"/> Disease (GERD) | <input type="checkbox"/> Parathyroid disorder |
| <input type="checkbox"/> Brain aneurysm | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Parkinson’s disease |
| <input type="checkbox"/> Brain/Spinal disorder | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Brain tumor | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Regular urinary tract |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> infection |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Swallowing disorder |
| <input type="checkbox"/> Chronic ear infections | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Traumatic brain injury |
| <input type="checkbox"/> Colon disease (e.g. Chron’s, IBS) | <input type="checkbox"/> Kidney disorder | <input type="checkbox"/> Tumor: _____ |
| <input type="checkbox"/> Concussion/head injury | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cushing’s syndrome | <input type="checkbox"/> Low testosterone | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Degenerative joint disease | <input type="checkbox"/> Lung disease | |

Has your child ever been exposed to any toxins, such as lead, mercury, solvents, etc.? Yes / No

If yes, please list what toxins: _____

Developmental Information

Were any of the following present to an unusual degree during the **first 6 years of life?**

Please check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Not calmed easily |
| <input type="checkbox"/> Clumsy, uncoordinated | <input type="checkbox"/> Headaches | <input type="checkbox"/> Poisoning/toxic exposure |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Head banging | <input type="checkbox"/> Poor weight gain |
| <input type="checkbox"/> Did/does not like to be held | <input type="checkbox"/> High fevers | <input type="checkbox"/> Restless |
| <input type="checkbox"/> Difficult to console | <input type="checkbox"/> Into everything, climbing | <input type="checkbox"/> Unresponsive |
| <input type="checkbox"/> Disrupted sleep | <input type="checkbox"/> Irritability | <input type="checkbox"/> Unusually active |
| <input type="checkbox"/> Drooling | <input type="checkbox"/> Masturbation | <input type="checkbox"/> Unusual number of accidents |
| <input type="checkbox"/> Easily agitated | <input type="checkbox"/> Nightmares | |

Other: _____

Please indicate if any of these items are true regarding your child:

True / False - Did not drink from a cup by 12 months

True / False - Did not feed self by 18 months

True / False - Could not dress self by age 4

True / False - Not potty trained by 3 during days

True / False - Bed wetting at night past age 4

Information Regarding Sleep

On average, how many hours of sleep does your child get a night? _____

What time does your child *go to bed*? _____

What time does your child *go to sleep*? _____

What time does your child wake up in the morning? _____

Are bed/sleep and wake times consistent through the week? Yes / No Consistent on the weekend? Yes / No

How many hours of sleep did your child get last night? _____

Does your child have difficulty falling asleep? Yes / No

Does your child have difficulty staying asleep? Yes / No

Does your child have difficulty waking up? Yes / No

Is your child groggy for an extended time when they wake up? Yes / No

Does your child experience nightmares? Yes / No

Does your child experience night terrors? Yes / No

Does your child sleepwalk? Yes / No

Does your child currently wet the bed? Yes / No

Sensory/Motor Development

Please provide the closest *approximate* age your child reached these developmental milestones:

- | | |
|---|---|
| <input type="checkbox"/> Smiled | <input type="checkbox"/> Ate finger foods |
| <input type="checkbox"/> Sat alone | <input type="checkbox"/> Fed self with spoon |
| <input type="checkbox"/> Crawled | <input type="checkbox"/> Tied shoelaces |
| <input type="checkbox"/> Stood | <input type="checkbox"/> Buttoned clothes |
| <input type="checkbox"/> Walked alone | <input type="checkbox"/> Toilet trained |
| <input type="checkbox"/> Ran | <input type="checkbox"/> Slept through the night |
| <input type="checkbox"/> Skipped/jumped | <input type="checkbox"/> Wrote name |
| <input type="checkbox"/> Rode a tricycle | <input type="checkbox"/> Held bottle without help |
| <input type="checkbox"/> Rode bicycle alone | |

The child is: Right Handed / Left Handed / Ambidextrous (uses both hands equally)

Has preferred handedness ever changed? Yes / No If yes, when did this occur? _____

Please indicate if your child currently has or previously had any of the following difficulties regarding *motor skills*.

- | | | |
|---|---|--|
| <input type="checkbox"/> Difficulty learning to tie shoes | <input type="checkbox"/> Difficulty learning to ride a bike | <input type="checkbox"/> Poor fine motor skills |
| <input type="checkbox"/> Poor visual-spatial skills | <input type="checkbox"/> Poor sense of direction | <input type="checkbox"/> Poor balance/coordination |
| <input type="checkbox"/> Resists sports | <input type="checkbox"/> Resists physical activity | |

Please indicate if your child has presented with any of the following *sensory* difficulties:

- | | | |
|---|---|--|
| <input type="checkbox"/> Talks incessantly | <input type="checkbox"/> Easily over-stimulated | <input type="checkbox"/> Doesn't like tags in clothes |
| <input type="checkbox"/> Is easily startled | <input type="checkbox"/> Doesn't like certain textures | <input type="checkbox"/> Very picky about food |
| <input type="checkbox"/> Has muscle or verbal tics | <input type="checkbox"/> Has difficulty with transitions | <input type="checkbox"/> Under-sensitive to sensory input |
| <input type="checkbox"/> Is inflexible/stubborn | <input type="checkbox"/> Over sensitive to sensory input | <input type="checkbox"/> Becomes upset at changes in routine |
| <input type="checkbox"/> Becomes upset when feet leave the ground | <input type="checkbox"/> Doesn't seem to notice when face/hands are messy | <input type="checkbox"/> Engages in repetitive behaviors |

Has your child been *evaluated* by an occupational or physical therapist? Yes / No

If so, when did it occur? _____

Who completed the assessment? _____

Has your child been provided occupational or physical therapy? Yes / No

If so, when did therapy occur? _____

Who provided occupational or physical therapy? _____

Speech/Language Development

Please provide the closest *approximate age* that your child reached these developmental milestones:

- _____ Said first words
- _____ Said 3-word sentence
- _____ Named colors
- _____ Recited ABC song

Please indicate if your child has or has had any of the following difficulties regarding *language skills*.

- | | | |
|---|---|--|
| <input type="checkbox"/> Articulation problems | <input type="checkbox"/> Word retrieval problems | <input type="checkbox"/> Gets tongue-tied/disfluent |
| <input type="checkbox"/> Difficulty expressing self | <input type="checkbox"/> Following multi-step directions | <input type="checkbox"/> Difficulty listening with distractions |
| <input type="checkbox"/> Has difficulty understanding what was said | <input type="checkbox"/> Asking for help | <input type="checkbox"/> Retelling stories/experiences (i.e. putting them in order/giving details) |
| <input type="checkbox"/> Has trouble describing things and people | <input type="checkbox"/> Needs extra time to respond | <input type="checkbox"/> Answering questions |
| | <input type="checkbox"/> Seems to have trouble “finding the word” he/she wants to say | <input type="checkbox"/> Getting to the point when talking |
| | | <input type="checkbox"/> Saying something another way when someone doesn’t understand |

How does your child usually communicate (check all that apply)?

- gestures
- single words
- short phrases
- sentences

Has your child been *evaluated* by a speech/language therapist? Yes / No

If so, when did it occur? _____

Who completed the assessment? _____

Has your child been provided speech/language (SLP) *therapy*? Yes / No

If so, when did therapy occur? _____

Who provided speech/language therapy? _____

Social Development

Please indicate if your child has any of the following difficulties regarding social skills:

- | | | |
|--|--|--|
| <input type="checkbox"/> Is bullied or teased | <input type="checkbox"/> Bullies or teases others | <input type="checkbox"/> Doesn't read social cues well |
| <input type="checkbox"/> Feels rejected by peers | <input type="checkbox"/> Feels picked on by peers | <input type="checkbox"/> Doesn't get jokes/sarcasm |
| <input type="checkbox"/> Timing seems off | <input type="checkbox"/> Acts awkward around peers | <input type="checkbox"/> Doesn't grasp points of view |

Academic Information

- Name of school: _____
- Address of school: _____
- School Phone#: _____ School Fax#: _____
- Teacher(s) Email Address(es): _____
- Current grade: _____
- Has your child had to repeat any grade level? (If yes, *please specify*): _____
- How long has your child been attending this school? _____
- Average amount of time spent on homework per night: _____ hours

Did your child have any, or does child currently receive any of the following services? If so, please list **date(s)** of occurrence:

- | | | |
|--|--|--|
| <input type="checkbox"/> IEP Testing | <input type="checkbox"/> 504 Plan | <input type="checkbox"/> Tutoring |
| <input type="checkbox"/> IEP* | <input type="checkbox"/> Tier II | <input type="checkbox"/> RTI |
| <input type="checkbox"/> Tier I | <input type="checkbox"/> Occupational therapy | <input type="checkbox"/> Tier III |
| <input type="checkbox"/> Speech pathology | <input type="checkbox"/> One-on-one assistance | <input type="checkbox"/> After-school care |
| <input type="checkbox"/> Behavior plan | <input type="checkbox"/> IQ Testing* | <input type="checkbox"/> AIG program |
| <input type="checkbox"/> Other special services: | | |

***Please provide a copy of documentation (e.g. IEP, IQ Testing) for ACAPS records.**

Please answer Yes or No to following questions regarding your child’s school behavior:

- Yes / No - Is your child reluctant to go to school?
- Yes / No - Does your child deny problems with school or try to hide problems from you?
- Yes / No - Does your child have a history of school phobia or fears related to school?
- Yes / No - Does your child have nightmares related to school?
- Yes / No - Does completion of homework require adult supervision or assistance?
- Yes / No – Do school problems appear to be subject related?
- Yes / No - Does your child have trouble making friends?
- Yes / No - Do people often tell you your child is less mature than his/her same-age peers?
- Yes / No - Is your child’s activity level inappropriate for his/her age?
- Yes / No - Is s/he picked on or bullied?
- Yes / No - Did your child engage in biting behavior in preschool?
- Yes / No - Is your child more defiant than his/her peers?

Please rate your child’s school experience *related to academic learning*:

- Preschool: Good / Average / Poor
- Kindergarten: Good / Average / Poor
- Grade school: Good / Average / Poor
- Middle school: Good / Average / Poor
- High school: Good / Average / Poor
- College: Good / Average / Poor

Please rate your child’s school experience *related to behavior*:

- Preschool: Good / Average / Poor
- Kindergarten: Good / Average / Poor
- Grade school: Good / Average / Poor
- Middle school: Good / Average / Poor
- High school: Good / Average / Poor
- College: Good / Average / Poor

Has/Have your child’s classroom teacher(s) reported concerns regarding any of the following?

- | | | |
|--|---|---|
| <input type="checkbox"/> Attention/concentration | <input type="checkbox"/> Activity level | <input type="checkbox"/> Not turning in assignments |
| <input type="checkbox"/> Peer problems | <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Learning problems |
| <input type="checkbox"/> Following directions | <input type="checkbox"/> Handwriting | <input type="checkbox"/> Behavior problems |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Social problems | <input type="checkbox"/> Aggression | <input type="checkbox"/> Low energy |
| <input type="checkbox"/> Academic problems | | <input type="checkbox"/> Other: _____ |

Please indicate if your child exhibits any of the following difficulties regarding reading skills:

- | | | |
|---|---|---|
| <input type="checkbox"/> Difficulty learning the alphabet | <input type="checkbox"/> Difficulty blending sounds | <input type="checkbox"/> Unable to read smoothly |
| <input type="checkbox"/> Poor tracking | <input type="checkbox"/> Mispronunciations | <input type="checkbox"/> Does not grasp the main idea |
| <input type="checkbox"/> Reads slowly | <input type="checkbox"/> Reverses letters | <input type="checkbox"/> Tires easily when reading |
| <input type="checkbox"/> Resists reading | <input type="checkbox"/> Poor recall | <input type="checkbox"/> Doesn’t understand what is read |
| <input type="checkbox"/> Difficulty completing long passages | <input type="checkbox"/> Difficulty comprehending longer passages | <input type="checkbox"/> Has trouble following written directions |
| <input type="checkbox"/> Has difficulty remembering details of what is read | <input type="checkbox"/> Has difficulty explaining what was read | |

Please indicate if your child has any of the following difficulties regarding math skills:

- | | | |
|---|---|---|
| <input type="checkbox"/> Poor understanding of concepts | <input type="checkbox"/> Difficulty doing steps in order | <input type="checkbox"/> Poor calculations |
| <input type="checkbox"/> Many careless errors | <input type="checkbox"/> Difficulty with basic facts | <input type="checkbox"/> Resists math |
| <input type="checkbox"/> Tires easily when doing math | <input type="checkbox"/> Poor recall of concepts | <input type="checkbox"/> Difficulty with spatial math |
| <input type="checkbox"/> Doesn’t show his/her work | <input type="checkbox"/> Difficulty holding numbers in their head | |

Please indicate if your child has any of the following difficulties regarding writing skills:

- | | | |
|---|--|--|
| <input type="checkbox"/> Poor handwriting | <input type="checkbox"/> Poor spelling | <input type="checkbox"/> Letter reversal |
| <input type="checkbox"/> Resists writing | <input type="checkbox"/> Writing below expectation | <input type="checkbox"/> Writing is laborious |
| <input type="checkbox"/> Poor capitalization | <input type="checkbox"/> Poor punctuation | <input type="checkbox"/> Poor grammar |
| <input type="checkbox"/> Problem with completion | <input type="checkbox"/> Difficulty starting assignments | <input type="checkbox"/> Difficulty organizing what to say |
| <input type="checkbox"/> Difficulty getting thoughts on paper | <input type="checkbox"/> Difficulty communicating by writing | |

Community Information

Please indicate if your child participates in any of the following, including what *type* and *how often* they participate:

Community sports: Yes / No

What type? _____

How often? _____

Working out at the gym: Yes / No

What type? _____

How often? _____

Community activities (clubs, scouts, etc.): Yes / No

What type? _____

How often? _____

Backyard sports: Yes / No

What type? _____

How often? _____

Other: _____ Yes / No

What type? _____

How often? _____

What age group does your child tend to spend more time with?

At school: Younger / Same-age / Older / Prefers to be alone

In the neighborhood: Younger / Same-age / Older / Prefers to be alone

With family friends: Younger / Same-age / Older / Prefers to be alone

With siblings/family: Younger / Same-age / Older / Prefers to be alone

Please give the *approximate* hours/minutes your child spends each day doing the following:

_____ Playing outside

_____ Watching TV

_____ Playing videogames

_____ On the internet

_____ Doing school-related homework

_____ Playing with friends

Behavioral Concerns

Does your child have a history of running away? Yes / No

If yes, please describe: _____

Does your child have a history of violent or aggressive behavior? Yes / No

If yes, please describe: _____

Does your child have current or past history of involvement with legal authorities? Yes / No

If yes, please describe: _____

Does your child have a history of substance abuse? Yes / No

If yes, please describe the type, amount, frequency, severity, and if/how the problem was dealt with: _____

Please indicate any and all behavior issues that your child may **currently** be exhibiting:

- | | | |
|--|---|--|
| <input type="checkbox"/> Impulsive | <input type="checkbox"/> Overly physically active | <input type="checkbox"/> Can't sit still for long |
| <input type="checkbox"/> Difficulty organizing belongings | <input type="checkbox"/> Difficulty following directions | <input type="checkbox"/> Defiant or oppositional |
| <input type="checkbox"/> Avoids homework | <input type="checkbox"/> Forgetful | <input type="checkbox"/> Careless mistakes |
| <input type="checkbox"/> Loses things often | <input type="checkbox"/> Can't sustain attention for long | <input type="checkbox"/> Doesn't listen when spoken to |
| <input type="checkbox"/> Has difficulty waiting their turn | <input type="checkbox"/> Is easily distracted | <input type="checkbox"/> Fidgety or restless |
| | | <input type="checkbox"/> Interrupts others |

If above item(s) checked, please explain:

Are there any additional behaviors your child exhibits that have you concerned? Yes / No

If yes, please explain: _____

Please check any and all guidance and disciplinary techniques that are used with the child in the home?

- Ignore problem behavior Verbal reprimand Spanking
 Redirect interests Reason with the child Time out
 Remove privileges Other:

Emotional Concerns

Has your child ever participated in therapy? Yes / No

If yes, when? _____

Name of psychotherapist? _____

Has your child ever been placed in a psychiatric hospital? Yes / No

If yes, how many times has your child required a psychiatric hospitalization? _____

If yes, please provide approximate date(s) of occurrence? _____

Name of Provider / Location(s)? _____

Are you worried about your child’s self-esteem? Yes / No

If yes, please explain why: _____

Are you worried about your child’s moods or emotions? Yes / No

If yes, please explain why: _____

Are you worried about your child’s level of anxiety? Yes / No

If yes, please explain why: _____

Has your child ever expressed any suicidal ideation or desires? Yes / No

If yes, please provide how often, when the most recent incident occurred, and any other relevant details: _____

Has your child ever attempted suicide? Yes / No

If yes, please provide date(s), method(s), and any other relevant details regarding the event: _____

Has your child ever experienced abuse? Yes / No

If yes, please provide when and what type: _____

Has your child experienced the death of a close loved one? Yes / No

If yes, please provide the relationship of the loved one and when this occurred: _____

Has your child ever experienced any difficult moves or transitions? Yes / No

If yes, please explain and provide dates: _____

Miscellaneous Information

Please list any hobbies or activities that your child enjoys: _____

What would you say are your child's best traits? _____

Any additional information you would like us to know about your child? _____