DEMOGRAPHIC FORMS-CHILD EVALUATION

General Information

Today's Date: ___/___/_____ Child's Date of Birth: ___/___/_____ Child's Age: _____
Child's Full Name: _____
Your Name: _____
Relationship to Child: _____

Mother's Information
Mother's Address: _____
_____

Phone: Home: _____ Is it okay to leave a detailed message at this number? Yes ___ No ___
Cell: _____ Is it okay to leave a detailed message at this number? Yes ___ No ___
E-Mail Address: _____
Do I have your consent to email an appointment reminder prior to sessions? Yes ___ No ___
Do I have your consent to email digital copies of:
1) Records: Yes ___ No ___
2) Billing statements: Yes ___ No ___

Father's Information
Father's Address:_____ _____
_____
Phone: Home: _____ Is it okay to leave a detailed message at this number? Yes ___ No ___
Cell: _____ Is it okay to leave a detailed message at this number? Yes ___ No ___
E-Mail Address: _____
Do I have your consent to email an appointment reminder prior to sessions? Yes ___ No ___ Do I have your consent to email digital copies of:
1) Records: Yes ___ No ___
2) Billing statements: Yes ___ No ___

Emergency contact or parent/guardian name: _____
Phone #: _____ Email Address: _____

Who referred you to our service? Please provide contact information: _____
_____
_____
Please list the reason(s) for referral or primary concerns that led you to seek an evaluation at this time: _____
_____
_____
_____
Have there been any family changes or difficulties (e.g., new baby, divorce, family arguments, etc.) which may be related to these problems? If so, please explain. _____
_____
_____
Describe your child's BEST behavior traits: _____
_____
_____

For the following list, read each problem and check for persistence.

PROBLEM	PERSISTANCE		
	Not a problem	Present in most situations	Present in all situations
Often fidgets with hands or feet, squirms in seat (in adolescents, may be limited to subjective feelings of restlessness)			
Has difficulty remaining seated when required to do so			
Is easily distracted by extraneous stimuli			
Has difficulty waiting turn in games or group situation			
Often blurts out answers to questions before they have been completed			
Has difficulty following through on instructions from others (not due to oppositional behavior or failure to comprehend), i.e., fails to finish chores			
Has difficulty sustaining attention in tasks or play activities			
Often shifts from one uncompleted activity to another			
Has difficulty playing quietly			
Often talks excessively			
Often interrupts or intrudes on others, i.e., butts into other children's games			
Often does not seem to listen to what is being said to him/her			
Often loses things necessary for tasks or activities at school or home, i.e., pencils, books, assignments			
Often engages in physically dangerous activities without considering possible consequences (not for thrill seeking), i.e., runs into the street without looking			

Please tell us a little more about your child:

Gender/Preferred pronouns: _____
Ethnicity: _____
Spiritual beliefs: _____
Disability (if any): _____
Sexual orientation: _____
School & Grade: _____
Handedness: _____

Developmental/Medical History

Pregnancy and Birth

Pregnancy/Birth/Delivery Complications? Please Describe: _____
_____
_____

Medications used during pregnancy. _____
_____

Yes No Smoking? How much? _____
Yes No Drug Intake? Type? _____ How much? _____
Yes No Alcohol? How much? _____

Length of pregnancy? (weeks): _____
Birth weight: _____lbs. _____ oz.
Birth length: _____
APGAR scores: _____/_____
Type of delivery: _____ spontaneous _____induced _____caesarean _____with instruments _____ breech

Any complications for mother or infant after birth? Please explain: _____
_____
_____
Did mother receive prenatal care, and if so, when? _____
_____
Did mother eat well during pregnancy? _____
Did mother have any illnesses such as the flu, cold, kidney infection, high blood pressure, gestational diabetes, seizures, or an operation during pregnancy?_____
_____

Developmental Milestones

Yes No Enjoyed cuddling
Yes No Fussy, irritable
Yes No More active than other babies
Yes No If child has other siblings, was development different in any way? Explain: _____
_____
_____

At what age did this child first do the following (indicate with year and month of age).

First smile (.5-4m)_____
Rolled front to back (2-4m)_____
Sit up alone (5-10m)_____
Crawled (5-11m)_____
Had vocabulary of 5 words (18-30m)_____
Said 2-3 word phrases (16-30m)_____
Able to tie shoes_____
Grabbed objects (3-7m)_____
Pulled up to stand (6-12m)_____
Took 2-3 steps alone (9-12m)_____
Rode tricycle_____
Rode bicycle_____
Fed self with cracker_____
Dress self (buttons, zippers, and snaps)_____

Is child toilet Trained? **Yes No** If yes, Days? _____ Nights? _____

Did bed wetting or soiling occur after training? **Wetting** **Soiling** If yes, until what age? _____

Does your child have any speech difficulties? _____

Motor difficulties (e.g. clumsiness)? _____
Does your child have difficulties with hygiene? _____

Please list any other healthcare providers involved in your child's care (e.g., neurologists, pediatricians or other physicians, psychologists, social workers, therapists, special educators, occupational therapists, etc.)

_____
_____
_____

Medical History

Yes No Has your child's medical history been normal/unremarkable? If no, please explain: _____
_____
_____

Yes No Has your child received any medical diagnoses? Please specify: _____
_____
_____

Yes No Has your child had genetic testing?
Yes No Has your child had an MRI?
Yes No Has your child had an EEG?
Yes No Frequent ear infections?
Yes No Were ear tubes ever placed?
Yes No Hearing problems?
Yes No Vision problems?
Yes No Headaches?

Yes No Meningitis?
Yes No Seizures?
Yes No Asthma?
Yes No Slow/fast growth?
Yes No Head injury?
Yes No Allergies?
Yes No Hospitalizations? Describe below.
Yes No Physical/Sexual Abuse?

If yes to any of the above, please describe: _____
_____
_____

Has your child ever been hospitalized, had surgeries, or major illnesses?

Age	*How long*	*Reason*
____	_____	_____
____	_____	_____

What medications does your child currently take? (Include over-the-counter supplements)

Name	*Dose*	*Frequency*	*Reason*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe your child's sleep routine:
Typical bed time: _____
Typical wake time:
_____

Trouble falling asleep? **Yes No**
Trouble staying asleep? **Yes No**
Trouble waking up early? **Yes No**

Any other sleep problems? Explain: _____

_____

Describe your child's diet: _____
_____

Describe your child's current level and type(s) of exercise: _____
_____
_____

Mental Health History

Has your child had previous neuropsychological testing? **Yes No**
If Yes, where? _____ When? _____

Has your child had any additional testing (e.g., psychoeducational, speech/language?) **Yes No**
If Yes, where? _____ When? _____
**If you answered Yes to either of the above questions, please attach or otherwise provide report(s).*

Has your child received psychotherapy services or counseling in the past? **Yes No**
If Yes: Name of provider: _____ Dates: _____
If Yes, for what reason:_____

Is your child seeing a psychiatrist for medication? **Yes No**
Name of Psychiatrist: _____ Dates: _____
Medication the Psychiatrist Prescribed: _____

Is there any history of self-harm or suicidal thoughts, threats, or attempts? Please Explain: _____
_____
_____

List any previous or current mental health diagnoses: _____
_____
_____

Psychosocial Functioning

Describe the child's personality: _____
_____
_____

What are your child's non-academic strengths? _____
_____

What are your child's non-academic weaknesses? _____
_____

How does the child spend his/her free time? _____
_____

In what community or extracurricular activities is your child involved? _____
_____
_____

Any concerns about child's social group/friends? Explain: _____

_____
_____

Any concerns about substance use? Explain: _____
_____
_____

Please place a mark next to behaviors that you believe your child exhibits to an *excessive or exaggerated degree* when compared to other children his or her age.

Sleeping and Eating

- ❑ Nightmares
- ❑ Trouble falling asleep
- ❑ Trouble staying asleep in the morning
- ❑ Decreased need for sleep without getting tired
- ❑ Excessive snoring during sleep
- ❑ Eats Poorly
- ❑ Eats excessively

Social Development

- ❑ Prefers to be alone
- ❑ Excessively shy or timid
- ❑ More interested in objects than people view
- ❑ Difficulty making friends
- ❑ Teased by other children
- ❑ Bullies other children
- ❑ Excessive daydreaming and fantasy life

Motor Skills

- ❑ Poor fine motor coordination
- ❑ Poor gross motor coordination
- ❑ Generally "clumsy

Other Problems

- ❑ Bladder control problems
- ❑ Poor bowel control (soils self)
- ❑ Any history of motor/vocal tics
- ❑ Overreacts to noises
- ❑ Overreacts to touch
- ❑ Problems with taste or smell

Behavior

- ❑ Stubborn
- ❑ Irritable, angry, or resentful
- ❑ Frequent tantrums
- ❑ Strikes out at others
- ❑ Throws or destroys things
- ❑ Lying
- ❑ Stealing
- ❑ Argues with Adults
- ❑ Low frustration threshold
- ❑ Daredevil behavior
- ❑ Runs away
- ❑ Needs a lot of supervision
- ❑ Doesn't empathize with others
- ❑ Overly trusting of others
- ❑ Doesn't appreciate humor
- ❑ Impulsive (does things without thinking)
- ❑ Poor sense of danger
- ❑ Skips school
- ❑ Seems depressed
- ❑ Cries frequently
- ❑ Excessively worried and anxious
- ❑ Overly preoccupied with details
- ❑ Overly attached to certain objects
- ❑ Not affected by negative consequences
- ❑ Drug use
- ❑ Alcohol use
- ❑ Sexual activity, behavior, or sexual talk
- ❑ Not sought out for friendship by peers
- ❑ Difficulty seeing another person's point of view

Family History

Parents are (choose one): **Married** **Separated** **Divorced** **Living Together**
If separated or divorced; how old was the child when the separation occurred? _____
Child lives with (choose one): **Both parents** **Mother** **Father** **Other**
Who has legal custody? _____
Who else lives in the home? _____

Biological Mother
Current age: _____
Name: _____
Occupation: _____
Highest grade completed: _____

Biological Father
Current age: _____
Name: _____
Occupation: _____
Highest grade completed: _____

Siblings:

Name	Age	Medical, social, academic, mental health concerns

Have any of the following conditions occurred among the child's blood relatives (parents, aunts, uncles, grandparents)? Check those that apply:

- ❑ Allergies
- ❑ Amnesia
- ❑ Asthma
- ❑ ADHD/ADD
- ❑ Bleeding tendency
- ❑ Depression/Bipolar disorder
- ❑ Cancer
- ❑ Suicide
- ❑ Dyslexia or math struggles
- ❑ Deafness
- ❑ Diabetes
- ❑ Glandular problems
- ❑ Heart diseases
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Alcohol/drug problem
- ❑ Anxiety/OCD/Panic
- ❑ Tics
- ❑ Autism/Asperger's
- ❑ Intellectual disability/ cognitive delay
- ❑ Seizures
- ❑ Cerebral Palsy
- ❑ Migraines
- ❑ Muscular Dystrophy
- ❑ Other (specify): _____

Does anyone in the family have similar difficulties to the child? If yes, please describe:
_____
_____

If child is adopted...
Adoption source: _____
Reason and circumstances: _____
Age when child first in home: _____ Date of legal adoption: _____
What has the child been told regarding their adoption?_____

Academic History

Child's current grade: _____
School Name: _____ **Public Private**
School District: _____

What preschool experience did your child have? _____
Were there any problems detected in your child's kindergarten screening? **Yes No**
If yes, please explain: _____
_____

Does your child have an IEP or 504 Plan, or another modified learning program? **Yes No**

Is your child in a regular classroom? **Yes No**
If no, please explain: _____

Please check any services child currently receives through an IEP or 504 Plan (if applicable):

____ Speech therapy ____ Occupational therapy ____ Physical therapy
____ Adaptive PE ____ Tutoring ____ Pull-out services (math, reading, writing)

What are your child's typical grades? _____
How does your child typically perform on standardized tests/district assessments? _____
What are your child's strongest and weakest points, academically? _____
_____

Are you satisfied with your child's educational program? **Yes No**
If no, please explain:_____
_____
_____

Legal History

Has the child been involved with the court currently or in the past? _____
Date(s): _____
Describe:_____
_____
_____

Current Probation? **Yes No** Probation Officer: _____ Phone #: _____

Is there any other pertinent information to your child's evaluation that you would like to include here? Do you have any questions you would like to ask your child's clinician at your intake appointment? (This section can be left blank):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____