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# CHILD INFORMATION FORM

Please complete the following form. Use additional paper if necessary to respond to questions or provide additional documentation.

**Patient Information:**
**Full Name** _____
**Preferred Name:** _____ **Gender Preference** _____
**Age** _____ **Date of Birth** _____
**Grade** _____ **School** _____

**Parent Information:**
**Name** _____ **Relationship** _____
**Address (including zip code**) _____
_____
**Home or Cell Phone Numbe**r (including area code): _____
**Occupation** _____
**Years of Completed Education or Degree** _____
**Work Phone Number** (including area code) _____
**Marital Status** _____ **Number of Marriages**_ _____
**If Remarried or Living with Another Adult, Name, Years of Education, and Occupation of Current Partner**_____
_____

**Name** _____ **Relationship** _____
**Address (including zip code**) _____
_____
**Home or Cell Phone Numbe**r (including area code): _____
**Occupation** _____
**Years of Completed Education or Degree** _____
**Work Phone Number** (including area code) _____
**Marital Status** _____ **Number of Marriages**_ _____
**If Remarried or Living with Another Adult, Name, Years of Education, and Occupation of Current Partner**_____
_____

**Siblings** (Name, Full/Half/Step, Date of Birth, Primary Residence): _____

**Presenting Concerns:**
**Please indicate what specific problems or concerns, if any, related to your child led you to seek evaluation and/or consultation at this time** _____

**When did you first have these concerns?** _____

**By seeking evaluation and/or consultation, what changes or outcomes regarding your child do you hope for?** _____

**Has your child participated in a previous psychological or educational evaluation? When, with whom, and for what reason(s)? What conclusions were reached? Do you feel that these conclusions were valid? Please provide copies of all evaluations.** ____

**Developmental History:**
**If your child was adopted, please indicate the age at adoption, describe what you know about your child's life prior to adoption, and answer any additional questions for which you have available information.** _____

**Briefly describe the pregnancy. Were there any problems or complications during the pregnancy? Was pregnancy with full term? (If not, indicate length of the pregnancy.)**

_____
_____

**Were any complications noted during labor or delivery? Was this child delivered vaginally or by Cesarean section? (Please describe any complications.)**

_____
_____
_____

**Child APGAR (if known) _____**
**Birth Weight _____**
**Please describe the health of your child at birth, including any complications or need for treatment. _____**

_____
_____
_____

**Did your child leave the hospital within a normal period of time? (If not, please explain)**

_____
_____
_____

**Describe your child as an infant (cuddly, difficult, colicky, active, etc.)? _____**

_____
_____
_____
_____

**At what age did your child:**
Smile in response to those around him or her? _____
Roll over from stomach to back? _____
Crawl? _____
Walk without holding on? _____
Use single words? _____
Use two to three word sentences? _____
Remain dry during the day? _____
Remain dry at night? _____

**Has your child not attained normal development in any domain? Has your child ever lost previously gained skills? (Please explain.) _____**

_____
_____
_____

_____
_____

**Please indicate (by checking it) whether your child has evidenced any of the following:**

Problems with Feeding or Eating _____
Temper Tantrums _____
Excessive Hitting _____
Biting _____
Self-Injurious Behaviors _____
Social Withdrawal _____
Rocking _____
Shyness _____
Problems with Sleep _____
Excessive Fears _____
Excessive Activity Level _____
Difficulty Sitting Still _____
Difficulty Paying Attention or Focusing _____
Difficulty Completing Schoolwork _____
Disorganization _____
Repetitive or Compulsive Behaviors _____
Hand flapping or Toe-walking _____
Repetitive Vocalizations _____
Poor Social Skills _____
Defiance _____
Lying _____
Excessive Rule-Breaking _____
Cutting _____
Suicidal Thoughts _____
Suicidal Attempts _____
Trouble with the Law _____
Running Away _____
Truancy _____
Problems with Drugs or Alcohol _____
Trauma _____
Gender concerns _____
Sexual Molestation or Abuse _____
Sexual Acting Out _____
Other_____ (Please indicate below)

**If you have checked any of the above behaviors, please explain the behaviors and at what age the behavior was observed** _____
_____
_____

_____
_____
_____
_____

**Has your child received any early intervention services (speech-language, occupational, physical, developmental, etc.)? If so, please describe the history of these services.**

_____
_____
_____
_____

**Childcare History:**
**Please indicate who has cared for your child since birth to the present when you are not home or when your child is not in school.** _____
_____
_____
_____
**What problems, if any, have been noted in childcare?** _____
_____
_____

**Educational History:**
**Please indicate name of school (if different from the previous year) and what problems (if any) were noted, including learning problems, behavioral problems, referral for special services, suspensions or expulsions, retention, or other problems?**

**Preschool and/or Pre- kindergarten (including age at attendance)** _____
_____
**Kindergarten (including age at attendance)** _____
_____
**First Grade** _____
_____
**Second Grade** _____
_____
**Third Grade** _____
_____
**Fourth Grade** _____
_____
**Fifth Grade** _____
_____
**Sixth Grade** _____
_____

**Seventh Grade** _____
_____
**Eighth Grade** _____
_____
**Ninth Grade** _____
_____
**Tenth Grade-** _____
_____
**Eleventh Grade** _____
_____
**Twelfth Grade** -_____
_____
**Has your child ever been retained in a grade?** _____
**Has your child ever received special education services?** _____
**If so, for what reason?** _____
**Has your child ever received tutoring outside of school?** _____
**Does your child like school? _** _____

**Medical History:**
**Has your child participated in a previous psychological evaluation? When, with whom, and for what reason(s)?** _____
_____
_____
**Has your child participated in previous counseling? When, with whom, and for what reason (s)?** _____
_____
_____
**Does your child have any current medical problems? Please explain.** _____
_____
_____
_____
_____
**Does your child have a history of any medical problems? Please explain.** _____
_____
_____
_____
_____
**Please indicate what medications, including dosage and time of administration, your child is currently taking on a regular basis, why your child is taking hat medication, and who is the prescriber.** _____
_____
_____
_____
**Has your child ever been hospitalized? Please explain.** _____

_____
_____
_____

**Has your child ever had surgery? Please explain.** _____

_____
_____

**Child's Physician (Name, Address, Phone Numbe**r) _____

_____

**Has your child's vision been tested recently? Results?** _____

_____

**Has your child's hearing been tested recently? Results?** _____

_____

**Has your child been evaluated by an occupational therapist? Results?**

_____

**Interests:**

**Does your child participate in any sports activities? Please describe.** _____

_____
_____
_____

**What are your child's favorite activities, hobbies or interests?** _____

_____
_____
_____

**Does your child participate in any club or other organization on a regular basis? If so, what clubs or organizations?** _____

_____
_____

**What special skills or talents does your child have?** _____

_____
_____
_____

**Extended Family History:**

**Please indicate (and explain briefly) if any extended family member (blood relation) has or had problems in any of the following areas:**

Cognitive Impairment/Mental Retardation: _____
Autism :_____
Learning Disability (problems with reading, writing, spelling, math): _____

_____

Attention Problems: _____
Problems Completing School: _____
Behavior Problems: _____
Strong Temper: _____

Anxiety or Worry: _____
Shyness: _____
Obsessions or Compulsions: _____
Panic Attacks: _____
Excessive Fears or Phobias: _____
Depression: _____
Bipolar or Cyclical Depression: _____
Suicide (attempts or completed suicide): _____
Hallucinations or Delusions: _____
Alcohol or Drug Problems: _____
Trouble with the Law: _____
Other: _____

**What family stressors may impact (or have impacted) on your child's current functioning. Please explain.** _____

_____
_____
_____
_____
_____
_____

**Any Additional Information:**

**Please provide any additional information that may be helpful in understanding your child's needs**. _____

_____
_____
_____
_____
_____
_____

**Name of Person Completing This Form** _____

**Date of Form Completion** _____