

Parent/Guardian: Female: _____ <input type="checkbox"/> Biological Mother <input type="checkbox"/> Step-Mother <input type="checkbox"/> Adoptive Mother <input type="checkbox"/> Grandmother <input type="checkbox"/> Other Female Relative <input type="checkbox"/> Unrelated Female Male: _____ <input type="checkbox"/> Biological Father <input type="checkbox"/> Step-Father <input type="checkbox"/> Adoptive Father <input type="checkbox"/> Grandfather <input type="checkbox"/> Other Male Relative <input type="checkbox"/> Unrelated Male	Biological Parents and Guardian Information Age: _____ Education: _____ Occupation: _____ Work Title: _____ Employer: _____ <i>If not biological mother</i> Age: _____ Education: _____ Occupation: _____ Work Title: _____ Employer: _____ Age: _____ Education: _____ Occupation: _____ Work Title: _____ Employer: _____ <i>If not biological father</i> Age: _____ Education: _____ Occupation: _____ Work Title: _____ Employer: _____												
The Child Is:	<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Other												
The Child's Parents Are:	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Never Married												
Please list all brothers and sisters, including full, half and step-siblings.	<table> <tr> <td>Name: _____</td> <td>Age: _____</td> <td><i>Living with Child ?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Name: _____</td> <td>Age: _____</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Name: _____</td> <td>Age: _____</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Name: _____</td> <td>Age: _____</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	Name: _____	Age: _____	<i>Living with Child ?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	Name: _____	Age: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name: _____	Age: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name: _____	Age: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____	Age: _____	<i>Living with Child ?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No											
Name: _____	Age: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No											
Name: _____	Age: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No											
Name: _____	Age: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No											
Please list anyone else living in the child's home, and indicate their relationship to the child.													
Are there any significant stressors or pressures on the family?													
Pregnancy and Birth History													
Mother's age for this pregnancy and number of this pregnancy:	Age: _____ This Pregnancy was: <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third ____ th												
Did the child's mother have any health problems during her pregnancy with the child? If yes, please describe.	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____												
During the pregnancy, did the mother?	Drink Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No Use Drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No												
The baby was born:	<input type="checkbox"/> Full Term <input type="checkbox"/> Premature (_____ weeks early) <input type="checkbox"/> Late Birth Weight: ___ lbs ___ oz												

How was the child born?	<input type="checkbox"/> Vaginal Delivery	<input type="checkbox"/> Cesarean Section
Did the baby breathe on his/her own right away?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Apgar Scores (if known):	____ One Minute	____ Five Minutes
Were any delivery complications or birth defects noted? If yes, please describe.	<input type="checkbox"/> No	
Were forceps or suction used in the delivery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How soon after birth was the baby discharged from the hospital?		
Any problems in the first year of life? If yes, please describe.	<input type="checkbox"/> No	
Did the baby have to return to the hospital during his/her first year of life? If yes, why?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Developmental History		
Motor		
At what age did the child:	Sit Up: _____	Crawl: _____ Walk: _____
Was the child slow to develop motor skills or awkward in comparison to his/her brothers and sisters?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Handedness:	<input type="checkbox"/> Right	<input type="checkbox"/> Left <input type="checkbox"/> Both
Family history of left-handedness? If yes, please list left-handed relatives.		
Has the child ever had Occupational Therapy (OT) or Physical Therapy (PT)? If yes, please explain.	<input type="checkbox"/> No	<input type="checkbox"/> Yes: _____
Language		
At what age did the child:	Speak First Word: _____	Put 2-3 Words Together: _____
Any history of poor sucking, problems chewing or late drooling? If yes, please describe.	<input type="checkbox"/> No	<input type="checkbox"/> Yes: _____
Any history of speech delays or problems (e.g., difficult to understand, stuttering)? If yes, please describe.	<input type="checkbox"/> No	<input type="checkbox"/> Yes: _____
Has the child ever had Speech-Language Therapy? If yes, please describe.	<input type="checkbox"/> No	<input type="checkbox"/> Yes: _____
Any language other than English spoken in the home? If yes, please identify.	<input type="checkbox"/> No	<input type="checkbox"/> Yes: _____

Has the child ever lost developmental skills in any area? If yes, please describe.	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Toileting	
When was the child toilet trained?	For Urination: _____ For Bowel Movements: _____
Any problems with bed wetting, daytime urine accidents, or soiling? If yes, please describe.	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Temperament & Social Development	
As a baby, was your child easy to comfort or soothe?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Did your baby have colic?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Any trouble getting along with other children his/her age? If yes, please describe. Does your child have any difficulties getting or keeping friends?	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
The child gets along best with :	Children: <input type="checkbox"/> Same age <input type="checkbox"/> Younger <input type="checkbox"/> Older or <input type="checkbox"/> Adults
Which of the following best describes your child in social interactions:	<input type="checkbox"/> Does not hesitate to join in play with a group of children <input type="checkbox"/> Is sometimes hesitant to join in playing with other children, but does so when encouraged. <input type="checkbox"/> Hardly ever plays with other children, but instead prefers to play by himself or herself <input type="checkbox"/> Only interacts with family members <input type="checkbox"/> Does not typically seek out social interactions at all
Child and Family's Medical History	
Date of last physical exam:	<input type="checkbox"/> Less than 6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> 1-2 years ago <input type="checkbox"/> More than 2 years ago
Any problems with vision or hearing? If yes, please describe.	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Has the child ever had problems with recurrent ear infections or surgery to place PE tubes? If yes, please give details.	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
List any serious illnesses or injuries: hospitalizations or surgeries:	<input type="checkbox"/> None Or list incidents with dates: _____ _____ _____
Describe any head injuries (e.g., date, what happened, changes in behavior after the injury):	

List any hospitalizations or surgeries:	<input type="checkbox"/> None Or list hospitalizations with dates: _____ _____ _____
Has the child ever had: <i>(Check all that apply)</i>	<input type="checkbox"/> Seizures or Epilepsy <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Tics/Twitching <input type="checkbox"/> Exposure to Toxins <input type="checkbox"/> Lead Poisoning <input type="checkbox"/> Asthma and/or <input type="checkbox"/> Allergies
Current Medications, dosage, and reason:	
What medications (if any) have been used to address these concerns in the past?	
Has the child ever had a problem with: <i>(Check all that apply)</i>	<input type="checkbox"/> Social Skills <input type="checkbox"/> Impulsivity or Hyperactivity <input type="checkbox"/> Abdominal Pains/Vomiting <input type="checkbox"/> Temper Tantrums <input type="checkbox"/> Headaches <input type="checkbox"/> Worrying or Nail Biting <input type="checkbox"/> Sleep Difficulties <input type="checkbox"/> Clumsiness <input type="checkbox"/> Eating Difficulties <input type="checkbox"/> Self-Injurious Behavior <input type="checkbox"/> Aggression <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Noncompliance at Home <input type="checkbox"/> Noncompliance at School <input type="checkbox"/> Depressed or Sullen Mood <input type="checkbox"/> Suicidal Feelings or Actions
Do any family members have a history of problems learning? If yes, please describe.	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Does anyone in the family have a problem similar to the child's? If yes, please describe.	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Has your child had contact with a social agency, psychiatrist, psychologist, clinic or private agency? If yes, please describe.	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Is there any family history of mental health problems? If yes, please describe.	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Educational History	
Name, Address & Phone Number of Child's Current School:	Name: _____ <input type="checkbox"/> Public <input type="checkbox"/> Private School District: _____ Phone: (____) _____ - _____ Street Address: _____ City: _____ State: _____ Zip: _____

Nature of Current Placement:	<input type="checkbox"/> Current grade in school: _____ <input type="checkbox"/> Regular Classes <input type="checkbox"/> Resource Room <input type="checkbox"/> Special Education <input type="checkbox"/> ARD Process <input type="checkbox"/> IEP Intensity Level: _____ Other: _____
Any grades repeated or skipped? If yes, please describe.	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
The child's teachers report problems in: (Check all that apply)	<input type="checkbox"/> Reading <input type="checkbox"/> Attention/Concentration <input type="checkbox"/> Spelling/Writing <input type="checkbox"/> Daydreaming <input type="checkbox"/> Arithmetic <input type="checkbox"/> Behavior <input type="checkbox"/> Hyperactivity/Impulsivity <input type="checkbox"/> Social Adjustment <input type="checkbox"/> Other: _____
Check if the child attended or received:	<input type="checkbox"/> Child Find/Early Intervention <input type="checkbox"/> Head Start <input type="checkbox"/> Preschool <input type="checkbox"/> Kindergarten
Please provide the names and grades of attendance for all schools at which your child has been enrolled.	School: _____ For Grades: _____ School: _____ For Grades: _____ School: _____ For Grades: _____
My child's intelligence is likely:	<input type="checkbox"/> Below Average <input type="checkbox"/> Average <input type="checkbox"/> Above Average <input type="checkbox"/> Superior
Overall, I think my child is functioning like a child of what age?	
Consulting Professionals & Other Involvement	
<i>Please list all others involved in your child's care, including pediatricians or other physicians, psychologists, social workers, counselors, therapists, or special educators.</i>	
Name/Profession	Nature of their Involvement
Name/Profession	Nature of their Involvement
Name/Profession	Nature of their Involvement
Are you working with an attorney or is there any court action planned or underway concerning your child?	<input type="checkbox"/> No or None.
Child's Strengths/Additional Comments	
<i>Please use the space below, and the back of this page if necessary, to note your child's strengths and any additional important information.</i>	

We appreciate your time to complete this form. The information provided will be useful in caring for your child.