Powers Ferry Psychological Associates, L.L.C.

The Offices of:

Gerald S. Drose, Ph.D.
Dina M. Zeckhausen, Ph.D.
Steven Perlow, Ph.D.
David M. Schwartz, Ph.D., ABPdN
Abby L. Friedman, Ph.D.
Kimberly Smiley, Psy.D.
Jennifer Spring, Ph.D.

And the Offices of:

Martin Fleet, Ph.D.
Susan Berel, Ph.D.
Elaine Eassa, Ph.D.
Keith Helmken, LCSW
Jennifer Swales, Ph.D.
Rachel Scheinfield, Ph.D.
Brian Smith, Psy.D.
Katherine Higgins, Ph.D.

NEUROPSYCHOLOGICAL HISTORY

Please fill out this form to the best of your knowledge. If some questions are not applicable to you or your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

Form completed by: _____ Relationship to child: _____

Date form completed: _____ Email Address: _____

Child's Name: _____ Gender: ☐ Male ☐ Female
First *Middle* *Last*

Date of Birth: _____ Age: _____

Address (home): _____ Phone: _____

Race: _____ Eyes: _____ Hair: _____ Height: _____ Weight: _____

Ethnic/Cultural Background (optional): _____

Primary language spoken in the home: _____ Other language spoken in the home: _____

School: _____

Father - Age: _____ Occupation: _____ Education: _____

Mother - Age: _____ Occupation: _____ Education: _____

Birth Order – Brothers: _____ Sisters: _____

Reason for Referral: _____

_____

Who referred you to our office? How did you hear about our office? _____

If you **DO NOT want us to send a copy of our report to the referral source, please mark here ☐

Marietta/East Cobb
1827 Powers Ferry Rd., Bldg. 22
Atlanta, GA 30339
Office: 770.953.4744 / Fax: 770.953.4640

Buckhead
2964 Peachtree Road, Suite 324
Atlanta, Georgia 30305
(770) 953-4744

Canton
250 East Main Street, Suite 201
Canton, Georgia 30114
(770) 704-6159

CURRENT CONCERNS

What is the main reason for your child's referral today? _____

_____

How long has your child had these problems? _____

_____

What are you hoping to achieve at the completion of this evaluation? _____

_____

Is your child currently receiving psychological treatment? ☐ Yes ☐ No If yes, with whom and how often?

_____

What else have you tried to do to help your child with these problems, and how effective were these interventions? _____

_____

FAMILY

(Please circle: Birth, Adoptive, or Foster)

Birth / Adoptive / Foster Mother's Name: _____ Age _____ Education (Yrs) _____

Address (if different from child's) _____

Occupation: _____ Employer: _____

Work Phone: _____ Home Phone: _____

Birth/Adoptive/Foster Father's Name: _____ Age _____ Education (Yrs) _____

Address (if different from child's) _____

Occupation: _____ Employer: _____

Work Phone: _____ Home Phone: _____

Stepmother's Name: _____ Age _____ Education (Yrs) _____

Address (if different from child's) _____

Occupation: _____ Employer: _____

Work Phone: _____ Home Phone: _____

Stepfather's Name: _____ Age _____ Education (Yrs) _____

Address (if different from child's) _____

Occupation: _____ Employer: _____

Work Phone: _____ Home Phone: _____

Other Guardian's Name: _____ Age _____ Education (Yrs) _____

Address (if different from child's) _____

Occupation: _____ Employer: _____

Work Phone: _____ Home Phone: _____

Relationship to child: _____

FOSTER/ADOPTIVE INFORMATION

(Please complete this information only if the child has ever been adopted or placed in foster care)

At what age was the child first placed in foster care?: _____ Why was the child placed in foster care?: _____

_____

Who has legal custody of the child?: _____

Name of child's social worker: _____ Phone number: _____

Social worker address: _____

Has the social worker provided consent for this evaluation?: ☐ Yes ☐ No

(If YES, please attach authorization; If NO, please request authorization from county social services)

Is the child adopted?: ☐ Yes ☐ No If yes, specify country of origin if international: _____

Age when child was first in home: _____ Date of legal adoption: _____

If the child was adopted, do they know they were adopted?: ☐ Yes ☐ No

How many different foster care/adoptive placements has the child experienced?: _____

What type of placements has the child experienced (e.g., orphanage, foster home, group home, shelter care, kinship home, hospitalization, etc.): _____

Does the child have any contact with biological parents?: ☐ Yes ☐ No If yes, with whom, how often, are the visits supervised, how does the child respond after the visits?: _____

_____

If the child is not yet adopted, is there a plan for this to happen?: ☐ Yes ☐ No If yes, what is the time frame?: _____

How has the child adjusted to foster care/adoption?: _____

_____

List all family members/residents that reside in the house with the child:

Name	Age	Gender M/F	Relationship	Highest Grade Completed

If any brothers or sisters live outside the home, list their names, ages, where they are living, and why they are no longer in the home: _____

_____

Are parents separated?: ☐ Yes ☐ No Divorced?: ☐ Yes ☐ No

When did you separate or divorce?: _____

Who has physical custody of the child?: _____

Who has legal custody of the child?: _____

Does the other parent see the child?: ☐ Yes ☐ No If yes, how often?: _____

Have there been any major changes within the family life or child's living situation that may have affected your child's development (i.e., deaths; moves; divorce; loss of job; natural disaster, etc.)?: ☐ Yes ☐ No

If yes, please describe:

Event	Date	Child's Age

DEVELOPMENT

Did mother receive prenatal care during the pregnancy? ☐ Yes ☐ No If yes, starting in which month?: _____

Number of the following the child's mother has had (including the current child being evaluated):
Pregnancies _____ Miscarriages _____ Premature Births _____

Did mother have any of the following during or immediately before/after the pregnancy (check all that apply)

☐ Emotional stress
☐ Toxemia
☐ Excessive swelling (edema)
☐ Flu
☐ Vaginal bleeding-when?_____
☐ Epilepsy/seizure
☐ Other (Rh incompatibility, etc.)
☐ Infections (cold, flu)
☐ Anemia
☐ Measles/German measles
☐ High blood pressure
☐ Strep throat
☐ X-ray studies
☐ Diabetes
☐ Preterm labor/bed rest
☐ Abnormal weight gain
☐ Excessive vomiting
☐ Kidney disease
☐ Threatened miscarriage
☐ Fever
☐ Other virus
☐ Maternal injury. Describe: _____
☐ Operation/hospitalization during pregnancy. Reason: _____

Were any of the following used during mother's pregnancy? (check all that apply)

☐ Prescribed medications. (Please specify): _____ For: _____
☐ Tobacco
☐ Amphetamines
☐ Cocaine
☐ Marijuana
☐ Heroin
☐ Alcohol
☐ Methamphetamines
☐ Methadone
☐ Other (specify) _____

BIRTH HISTORY

Age of mother at birth? _____ Age of father at birth? _____

Was infant born full term? ☐ Yes ☐ No Number of weeks gestation _____

Birth weight: _____lbs. _____oz. APGARS (if remembered) _____ at 1 min _____ at 5 min.

Type of Labor Onset: ☐ Induced ☐ Spontaneous

Type of Birth: ☐ Vaginal ☐C/Section (Planned? ☐ Yes ☐ No Emergency? ☐ Yes ☐No)
☐ Vaginal Birth after C/Section (VBAC) ☐ With Instruments (forceps)

Type of Anesthesia: ☐ Gas ☐ Spinal ☐ Local ☐ None

Baby's Presentation: ☐ Breech ☐ Head ☐ Transverse (sideways)

Please check the following problems that may have occurred during labor:

Yes	No		Yes	No	
☐	☐	Toxemia/eclampsia	☐	☐	Fetal distress
☐	☐	Maternal fever	☐	☐	Medications used (please specify):

Length of active labor: _____hours. Describe any complications during delivery: _____

_____

POST-DELIVERY PERIOD

Check which of the following problems may have occurred after the child's birth, if known:

Yes	No		Yes	No	
☐	☐	Trouble breathing	☐	☐	Jaundice
☐	☐	Cord around the neck (# of times ____)	☐	☐	Poor feeding
☐	☐	Knot in cord	☐	☐	Did you nurse? How long? _____
☐	☐	Seizures	☐	☐	Required a blood transfusion
☐	☐	Hemorrhage (bleeding) in head	☐	☐	Vomiting / reflux
☐	☐	Hydrocephalus (water on the brain)	☐	☐	Floppy muscle tone
☐	☐	Cyanosis (turned blue)	☐	☐	Infection
☐	☐	Need for ventilation	☐	☐	Fever
☐	☐	Incubator care	☐	☐	Other _____

Did the infant require x-ray/CT scan? ☐ Yes ☐ No Was the infant placed in NICU? ☐ Yes ☐ No If yes, how long? _____

Length of stay in the hospital: Mother: _____ days Child: _____ days

Were any of the following present in the child during the first few years of life? If so, please explain on the back of the page.

Yes	**No**		**Yes**	**No**	
☐	☐	Did not enjoy cuddling	☐	☐	Was not calmed by being held or stroked
☐	☐	Difficult to comfort	☐	☐	Excessive restlessness
☐	☐	Excessive irritability	☐	☐	Frequent head banging
☐	☐	Difficult feeding	☐	☐	Sleeping difficulties
☐	☐	Extremely passive	☐	☐	Early learning problems
☐	☐	Temper tantrums	☐	☐	Withdrawn behaviors
☐	☐	Convulsions	☐	☐	Poor eye contact
☐	☐	Colic	☐	☐	Unable to separate from parent
☐	☐	Destructive behavior	☐	☐	Failure to thrive/poor weight gain
☐	☐	Breathing problems	☐	☐	Other:

Was your child adaptable, easy to please and easy to discipline as an infant and toddler? ☐ Yes ☐ No If no, please describe: _____

As an infant, was your child interested in social contact (i.e., eye contact, sharing, etc.)? ☐ Yes ☐ No If no, please describe: _____

Describe your child regarding his/her ease of self-regulation (i.e., ability to settle down at night, calm self when upset, etc.): _____

Please list the approximate age at which your child accomplished the following developmental milestones. If you feel the milestone is not appropriate yet for the age of your child, please write N/A. If unsure, please write DK for "I don't know."

Age	Skill	Age	Skill
_____	Smile in response (social smile)	_____	Knew primary colors
_____	Sit independently	_____	Say the letters of the alphabet
_____	Crawl independently	_____	Print first and last name
_____	Walk independently	_____	Tie shoes
_____	Say "mama" or "dada" specifically	_____	Snap, zip, button clothing
_____	Say 1st word other than "mama" or "dada"	_____	Began to read
_____	Put two words together	_____	Toilet trained (urine)
_____	Put 4–5 sentences together to relate an experience	_____	Toilet trained (bowel)
_____	You understood 100% of what child said		

Were there any concerns about toilet training? ☐ Yes ☐ No If yes, please explain: _____

_____

Has your child ever lost skills that he/she was able to perform at one time? ☐ Yes ☐ No If yes, please explain: _____

MEDICAL/HEALTH HISTORY

Physician: _____ Phone: _____

Address: _____

Date of last physical exam: _____

Vision problem? ☐ Yes ☐ No Date of last vision exam: _____

Hearing problem? ☐ Yes ☐ No Date of last hearing exam: _____

Appetite concerns? ☐ Normal ☐ Picky ☐ Eat too much ☐ Weight loss/gain

Oral-motor concerns? ☐ None ☐ Difficulty swallowing ☐ Drooling ☐ Gagging

Where does your child sleep? ☐ Own bedroom ☐ Bedroom parent(s) sleep in ☐ Shared bedroom with:

Does your child have problems falling asleep? ☐ Yes ☐ No If yes, how long does it take? _____

Does your child wake up in the middle of the night? ☐ Yes ☐ No If yes, how many times per night? _____

If yes, why? _____ How long does it take for them to go back to sleep? _____

Medication History:

Medication	Dosage	Frequency	Start date – End date	Reason for Discontinuing

Has your child been given a specific diagnosis?

☐ Learning Disability
☐ Language disorder
☐ Attention Deficit Disorder (ADHD)
☐ Oppositional Defiant Disorder (ODD)
☐ Autism/ Asperger's/ PDD
☐ Other
☐ Intellectual Disability
☐ Developmental Delay
☐ Epilepsy
☐ Tourette's Disorder
☐ Fragile X
☐ Genetic Disorder
☐ Anxiety Disorder
☐ Depression
☐ Bipolar Disorder
☐ Schizophrenia

Surgeries – (Age/Reason): _____

_____

Hospitalizations – (Age/Reason): _____

_____

Major accidents or injuries – (Age/Details): _____

_____

_____

Has your child ever been unconscious? ☐ Yes ☐ No If yes, please explain: _____

_____

Does your child have current problems with:

	Yes	No	?		Yes	No	?
Ears (specify) **R L Both**				**Appetite, digestion, stomach problems**			
Poor hearing				Frequent stomach aches			
Chronic earaches/infections				Poor eating habits			
Draining ears				Frequent vomiting			
				Soiling or daytime accidents			
Eyes (specify) **R L Both**				Constipation			
Poor vision				Problems with weight			
Crossed eyes							
Wears glasses				**Hematology (Blood)**			
				Anemia			
Endocrine				Excessive bleeding or bruising			
Thyroid problems				Leukemia			
Diabetes				Sickle cell disease			
Hypo/Hyperpituitarism				Other:			
Growth problems							
Other:							
				Excretory System			
				Urine and/or bladder problems			
Nervous System				Bedwetting			
Frequent and/or severe headaches				Daytime wetting and/or accidents			
Seizures or convulsions				Urinary tract infections			
Tremors or twitches							
Coordination problems				**Respiratory System**			
Balance problems				Wheezing and/or asthma			
Frequent dizziness				Other:			
Other:							
Cancer				**HIV/AIDS**			

Has your child had any of the following?

Ear Tubes ☐ Yes ☐ No If yes, number of tube placements _____
Encephalitis ☐ Yes ☐ No
Meningitis ☐ Yes ☐ No
Poisoning or drug intoxication ☐ Yes ☐ No
Coma ☐ Yes ☐ No If yes, what was the cause? _____
Staring spells ☐ Yes ☐ No
Immune system disorders ☐ Yes ☐ No
Other significant illness ☐ Yes ☐ No

If yes to any of the above, please provide additional details: _____

_____

Has your child had any of the following tests or treatments?

	Yes	No	Date (month/year)	Where	Results
Neurologic Evaluation					☐ Normal ☐ Abnormal ☐ Don't know
CT Scan of head					☐ Normal ☐ Abnormal ☐ Don't know
MRI of head					☐ Normal ☐ Abnormal ☐ Don't know
EEG					☐ Normal ☐ Abnormal ☐ Don't know
Genetic Testing					☐ Normal ☐ Abnormal ☐ Don't know
Chemotherapy					☐ Normal ☐ Abnormal ☐ Don't know
Radiation Therapy					☐ Normal ☐ Abnormal ☐ Don't know
Other					☐ Normal ☐ Abnormal ☐ Don't know
					☐ Normal ☐ Abnormal ☐ Don't know

Has your child ever had: ☐ Traumatic Brain Injury ☐ Seizure ☐ CVA/Stroke ☐Aneurysm ☐ Heart Attack

If yes, please provide the details for each on the back side of this page:

Date: _____ Loss of Consciousness: ☐ Yes ☐ No If yes, how long? _____

PERSONAL/SOCIAL INFORMATION

What are your child's main hobbies and interests?: _____

What about your child makes you most proud?: _____

What does your child dislike doing most?: _____

How many ***close*** friends does your child have?: _____ Does your child have a best friend?: ☐ Yes ☐ No

If yes, how old is he/she?: _____ How long have they been friends?: _____

How easily does your child make friends?: ☐ Worse than average ☐ Average ☐ Better than average

Does your child have problems keeping friends?: ☐ Yes ☐ No

How well does your child get along with friends?: ☐ Worse than average ☐ Average ☐ Better than average

If worse than average, please explain: _____

Does your child get along best with: ☐ Older children ☐ Children of the same age ☐ Younger children

Social Activities: _____

Hobbies: _____

Amount of Social/Leisure Time/Week: _____

FAMILY MEDICAL HISTORY

Father's health, learning, mental health problems (please specify): _____

_____

Child's siblings' health, learning, mental health problems (please specify): _____

_____

Have any of the child's family members had the following problems/disorders? Please specify the family member's relationship to the child and whether the relationship is on the maternal (m) or paternal (p) side. Example: aunt (p) = aunt on the father's side.

	Family Member(s) Relation		Family Member(s) Relation
☐ Birth Defect	_____	☐ Reading Problem(s)	_____
☐ Genetic Disorder	_____	☐ Other Learning Disability	_____
☐ Cerebral Palsy	_____	☐ Speech/Language Delay	_____
☐ Migraines	_____	☐ Intellectual Disability	_____
☐ Multiple Sclerosis	_____	☐ Autism/Asperger's	_____
☐ Physical Handicap	_____	☐ ADHD	_____
☐ Huntington's Chorea	_____	☐ Oppositional Behaviors	_____
☐ Muscular Dystrophy	_____	☐ Antisocial Behavior	_____
☐ Sickle Cell Anemia	_____	☐ Aggression	_____
☐ Seizures/Epilepsy	_____	☐ Tics/Tourette's Disorder	_____
☐ Cancer	_____	☐ Anxiety/Nervousness	_____
☐ Diabetes	_____	☐ Obsessive-Compulsive	_____
☐ Heart Disease	_____	☐ Depression	_____
☐ Alcohol Abuse	_____	☐ Bipolar Disorder	_____
☐ Drug Abuse	_____	☐ Schizophrenia	_____
☐ Physical Abuse	_____	☐ Other (specify)	_____
☐ Sexual Abuse	_____	☐	_____

Have any maternal family members ever received extra help in school, early intervention, or special education services? ☐ Yes ☐ No If yes, who and why?: _____

EDUCATIONAL HISTORY

Has your child ever received Early Childhood Intervention services?: ☐ Yes ☐ No If yes, please explain:

_____

Did your child attend preschool?: ☐ Yes ☐ No If yes, at what age?: _____

Name of preschool: _____

Were there any adjustment problems?: ☐ Yes ☐ No If yes, please explain: _____

Were you concerned about your child's ability to succeed in preschool?: ☐ Yes ☐ No If yes, please explain:

_____

Name of your child's current school: _____

School District: _____

Address of school: _____

Phone number: _____ Grade: _____ Teacher: _____

Has your child ever been retained?: ☐ Yes ☐ No What grade(s)?: _____ Why?: _____

How often is your child absent from school?: ☐ Often ☐ Seldom ☐ Never

Usual reason for absence: _____

If your child is in school, please comment on the areas below:	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
Overall school performance					
Reading					
Writing					
Mathematics					
Relationship with teachers					
Relationship with peers					
Participation in organized activities					

Has testing been completed by the school?: ☐ Yes ☐ No Date: _____ ***(Please provide a copy)***

By whom?: _____

Present class placement: ☐ Regular Education class ☐ Special Education class (specify): _____
☐ Bilingual/ESL class ☐ Gifted and Talented

Does your child have an IEP (Individualized Education Plan)?: ☐ Yes ☐ No

Does your child have a 504 plan?: ☐ Yes ☐ No

Is your child currently participating in Response to Intervention (RTI)?: ☐ Yes ☐ No If yes, what Tier?: _____

Please provide copies of any plans/documents.

Special Education Categories: Please check all that apply (specify since what grade child has been in this placement):

Category	Grade
☐ Autism Spectrum Disorder (ASD)	_____
☐ Communication Disorder	_____
☐ Deaf – Blind	_____
☐ Developmental Delay	_____
☐ Emotional Disability (ED)	_____
☐ Hearing Impairment	_____
☐ Intellectually Disabled (ID)	_____
☐ Learning Disability (LD) Specify:	_____
☐ Multiple Disabilities	_____
☐ Orthopedic Impairment	_____
☐ Other Health Impaired (OHI)	_____
☐ Traumatic Brain Injury (TBI)	_____
☐ Visual Impairment	_____
☐ Other Specify:	_____

Have any of the following instructional modifications been attempted?:

- ☐ Oral tests
- ☐ Additional instructions
- ☐ Manipulatives in math
- ☐ Preferential seating
- ☐ Peer teaching
- ☐ Reduced paper and pencil work
- ☐ Repeated review
- ☐ Study carrel
- ☐ Extended time to complete assignments
- ☐ Shortened or modified assignments
- ☐ Study sheets
- ☐ Control of distractions
- ☐ Behavior modification program
- ☐ Instructional technology
- ☐ Outlines
- ☐ Positive reinforcers
- ☐ Behavior check cards/charts
- ☐ Predictable routines and classroom rules
- ☐ Increased positive feedback
- ☐ Other:

How successful have the above interventions been?: _____

Curriculum Materials

What are the names of your child's current textbooks and publishers (curricular materials)? Please note, you may have to ask your child's teacher(s).

English/Language Arts Curriculum: _____

Math Curriculum: _____

Science Curriculum: _____

Social Studies Curriculum: _____

History Curriculum: _____

Other Curricula: _____

BEHAVIOR AND DISCIPLINE

Please describe briefly any behavioral problems at school: _____

_____

_____

Has your child ever been assigned: Out of school suspension ☐ Yes ☐ No Number: _____

In school suspension ☐ Yes ☐ No Number: _____

Expulsions ☐ Yes ☐ No Number: _____

Please describe briefly any behavioral problems at home: _____

_____

_____

Types of discipline you use with your child:

☐ Rewards
☐ Time out
☐ Ignoring behavior
☐ Giving in to child
☐ Verbal reprimands/demands
☐ Removal of privileges
☐ Physical punishment
☐ Other (please specify): _____

Which form(s) of discipline has proven most effective?: _____

_____

Which form(s) of discipline has proven least effective?: _____

_____

Any other behavioral concerns or other comments: _____

_____

_____

_____

_____

SYMPTOM SURVEY

Below is a list of items and behaviors that commonly describe people. Please check all behaviors that your child currently exhibits or has exhibited in the past. Please add any helpful comments next to the items.

PROBLEM SOLVING

Current	Past	
☐	☐	Difficulty figuring out how to do new things
☐	☐	Difficulty making decisions
☐	☐	Difficulty planning ahead
☐	☐	Difficulty solving problems
☐	☐	Disorganized in his/her approach to problems
☐	☐	Difficulty understanding explanations
☐	☐	Difficulty doing things in the right order (sequencing)
☐	☐	Difficulty verbally describing the steps involved in doing something
☐	☐	Difficulty completing an activity in a reasonable period of time
☐	☐	Difficulty changing a plan or activity when necessary
☐	☐	Is slow to learn new things
☐	☐	Difficulty switching from one activity to another activity
☐	☐	Easily frustrated
☐	☐	Other problem solving difficulties:

SPEECH, LANGUAGE, AND MATH SKILLS

Current	Past	
☐	☐	Difficulty speaking clearly
☐	☐	Difficulty finding the right word to say
☐	☐	Not talking
☐	☐	Rambles on and on without saying much
☐	☐	Jumps from topic to topic
☐	☐	Odd or unusual language or vocal sounds
☐	☐	Difficulty understanding what others are saying
☐	☐	Difficulty understanding what you are reading
☐	☐	Difficulty writing letters or words
☐	☐	Difficulty reading letters or words
☐	☐	Difficulty with math
☐	☐	Other speech, language, or math problems:

SPATIAL SKILLS

Current	Past	
☐	☐	Confusion telling right from left
☐	☐	Has difficulty with puzzles, or assembling items from diagrams
☐	☐	Problems drawing or copying
☐	☐	Don't know your colors
☐	☐	Difficulty dressing (not due to physical difficulty)
☐	☐	Problems finding way around places he/she has been to before
☐	☐	Difficulty recognizing objects
☐	☐	Seem unable to recognize facial or body expressions of disapproval or emotions
☐	☐	Gets lost easily
☐	☐	Other spatial problems:

AWARENESS AND CONCENTRATION

Current	Past	
☐	☐	Easily distracted by: Sounds ☐ Sights ☐ Physical sensations ☐
☐	☐	Mind appears to go blank at times
☐	☐	Loses train of thought
☐	☐	Difficulty concentrating on what others say, but can sit in front of a TV for long periods
☐	☐	Attention starts out OK but can't keep it up
☐	☐	Other attention or concentration problems:

MEMORY

Current	Past	
☐	☐	Forget where he/she leaves things
☐	☐	Forget things that happened recently (e.g., last meal)
☐	☐	Forget things that happened days/weeks ago
☐	☐	Forget what he/she is supposed to be doing
☐	☐	Forget names more than most people do
☐	☐	Forget school assignments
☐	☐	Forget instructions
☐	☐	Other memory problems:
☐	☐	
☐	☐	

PHYSICAL

Current	Past	
☐	☐	Frequently complain of headaches or nausea How often?
☐	☐	Have dizzy spells How often?
☐	☐	Have pains in joints Where?
☐	☐	Excessive tiredness When?
☐	☐	Frequent urination or drinking
☐	☐	Other physical problems:

MOTOR AND COORDINATION

Current	Past	
☐	☐	Fine motor control problems (using a pen/pencil) **R side L side Both**
☐	☐	Clumsy **R side L side Both**
☐	☐	Weakness **R side L side Both**
☐	☐	Tremor **R side L side Both**
☐	☐	Muscles are tight or spastic **R side L side Both**
☐	☐	Odd movements (posturing, peculiar hand movements, etc.) **R side L side Both**
☐	☐	Drop things more than most people **R side L side Both**
☐	☐	Have an unusual walk
☐	☐	Balance problems
☐	☐	Other motor or coordination problems:

SENSORY

Current	Past	
☐	☐	Needs to squint or move closer to page to read **R side L side Both**
☐	☐	Problems seeing objects **R side L side Both**
☐	☐	Loss of feeling **R side L side Both**
☐	☐	Problems hearing sounds **R side L side Both**
☐	☐	Difficulty telling hot from cold **R side L side Both**
☐	☐	Difficulty smelling odors **R side L side Both**
☐	☐	Difficulty tasting food **R side L side Both**
☐	☐	Overly sensitive to: ☐Touch ☐ Light ☐ Noise
☐	☐	Other sensory problems:
☐	☐	

BEHAVIOR

Current	Past		Current	Past	
☐	☐	Aggressive	☐	☐	Nervous
☐	☐	Attached to things, not people	☐	☐	Nightmares, night terrors, sleepwalks
☐	☐	Toileting Accidents (day / night)	☐	☐	Quiet
☐	☐	Unusual behavior	☐	☐	Resists change
☐	☐	Bowel movements in underwear	☐	☐	Risk-taking
☐	☐	Dependent	☐	☐	Self-mutilates
☐	☐	Depressed	☐	☐	Self-stimulates
☐	☐	Eating habits are poor	☐	☐	Shy and withdrawn
☐	☐	Emotional	☐	☐	Sleeping habits are poor
☐	☐	Fearful	☐	☐	Swears a lot
☐	☐	Immature	☐	☐	Unmotivated

Does your child currently (within the past 6 months) display any of the following behaviors frequently?
These behaviors should occur more frequently than in others the same age

☐ Fainting, falling
☐ Clumsiness
☐ Shy, timid
☐ Social Isolation
☐ Lack of confidence
☐ Low self-esteem
☐ Crying episodes
☐ Unhappiness
☐ Concern with weight
☐ Sleep problem
☐ Anxiety
☐ Unusual fears
☐ Avoidance
☐ Laziness
☐ Other:

☐ Poor concentration
☐ Short attention span
☐ Distractibility
☐ Low frustration tolerance
☐ Impulsivity
☐ Hyperactivity
☐ Attention seeking
☐ Irritability
☐ Temper tantrums
☐ Oppositional behavior
☐ Noncompliance
☐ Defiance
☐ Lying

☐ Obsessive-compulsive behaviors
☐ Stereotyped/repetitive behaviors
☐ Memory loss
☐ Physical aggression
☐ Stealing
☐ Use of profanity
☐ Skipping work
☐ Fire setting
☐ Destructiveness
☐ Cruelty to animals
☐ Gang Involvement
☐ Cigarette use
☐ Alcohol / Substance use

Overall these symptoms have developed: ☐ Slowly ☐ Quickly

The symptoms occur: ☐ Occasionally ☐ Often

Over the past six (6) months, the symptoms have: ☐ stayed about the same ☐ worsened

SERVICES/INTERVENTIONS PREVIOUSLY SOUGHT

☐ Medical Evaluation
☐ Neuropsychological Evaluation
☐ Occupational Evaluation/Treatment
☐ Other:

☐ Neurological Exam/Evaluation
☐ Speech/Language Evaluation/Therapy
☐ Physical Therapy Evaluation/Treatment

☐ Psychiatric Exam/Evaluation
☐ Psychological Evaluation/Treatment
☐ Medication

Has your child had any of the following forms of psychological treatment? If so, how long did it last?

Individual psychotherapy	☐ Yes	☐ No	Duration of therapy?
Group psychotherapy	☐ Yes	☐ No	Duration of therapy?
Parenting classes	☐ Yes	☐ No	Duration of classes?
Residential treatment	☐ Yes	☐ No	Duration of placement?