

Problems Seeking Consultation For:

1. _____
2. _____
3. _____

Current Stressors/Triggers That "Cause" These Problems:

1. _____
2. _____
3. _____

Pregnancy:

- Complications: _____
- Alcohol Consumption During Pregnancy: _____ Amount: _____
- Smoking Consumption During Pregnancy: _____ Amount: _____
- Medications Taken During Pregnancy: _____
- X-Ray Studies During Pregnancy: _____ Duration of Pregnancy in Weeks: _____

Delivery:

- Complications: _____
- Infant Injured During Delivery? (If Yes, Specify Type): _____

Post-Delivery Period (While in Hospital):

- Birth Weight: _____ Total # of days baby was in the hospital after delivery: _____
- Respiration: Immediate _____ Delayed (If So, How Long) _____
- Cry: Immediate _____ Delayed (If So, How Long) _____
- Cyanosis (Turned Blue): _____ Incubator Care: _____ Number of Days: _____
- Suck: Strong: _____ Weak: _____ Infection(s) (Specify): _____
- Birth Defects (Specify): _____

Infancy/Toddler Period: Were any of the following present to a significant degree during the first few years of life? If so, please describe.

- Did not enjoy cuddling: _____
- Was not calmed by being held and/or stroked: _____
- Excessively Restlessness: _____
- Diminished sleep because of restlessness & easy arousal: _____
- Frequent head banging: _____
- Constantly into everything: _____
- Excessive number of accidents compared to other children: _____

When Did Your Child Reach the Following Developmental Milestones?

| Developmental Milestone | Age | Early | Normal Time | Late |
|--|-------|-------|-------------|-------|
| • Smiled: | _____ | _____ | _____ | _____ |
| • Sat without support: | _____ | _____ | _____ | _____ |
| • Crawled: | _____ | _____ | _____ | _____ |
| • Stood without support: | _____ | _____ | _____ | _____ |
| • Walked without assistance: | _____ | _____ | _____ | _____ |
| • Spoke first words besides "Ma-Ma" and "Da-Da": | _____ | _____ | _____ | _____ |
| • Said phrases: | _____ | _____ | _____ | _____ |
| • Said sentences: | _____ | _____ | _____ | _____ |
| • Bowel trained (Day): | _____ | _____ | _____ | _____ |
| • Bowel trained (Night): | _____ | _____ | _____ | _____ |
| • Bladder trained (Day): | _____ | _____ | _____ | _____ |
| • Bladder trained (Night): | _____ | _____ | _____ | _____ |
| • Rode tricycle: | _____ | _____ | _____ | _____ |
| • Rode bike w/out training wheels: | _____ | _____ | _____ | _____ |
| • Buttoned clothing: | _____ | _____ | _____ | _____ |
| • Tied shoelaces: | _____ | _____ | _____ | _____ |
| • Named colors: | _____ | _____ | _____ | _____ |
| • Said alphabet in order: | _____ | _____ | _____ | _____ |
| • Began to read: | _____ | _____ | _____ | _____ |

Rate your Child's Coordination in the Following Areas:

| | Good | Average | Poor |
|-----------------------|-------|---------|-------|
| • Walking: | _____ | _____ | _____ |
| • Running: | _____ | _____ | _____ |
| • Throwing: | _____ | _____ | _____ |
| • Catching: | _____ | _____ | _____ |
| • Shoelace Tying: | _____ | _____ | _____ |
| • Buttoning: | _____ | _____ | _____ |
| • Writing: | _____ | _____ | _____ |
| • Athletic Abilities: | _____ | _____ | _____ |

Comprehension and Understanding:

Do you consider your child to understand directions and situations as well as other children his or her own age? _____ If not, why not? _____

Intellectual Ability:

How would you rate your child's intelligence compared to other children? (Circle One)

Below Average

Average

Above Average

School:

* Rate your child's school experience related to Academic Learning:

Good Average Poor

- Nursery School: _____
- Kindergarten: _____
- Current Grade: _____

* To the best of your knowledge, at what *grade level* is your child currently functioning? (Circle One)
Reading Spelling Arithmetic

* Has your child ever had to *repeat a grade*? If so, when: _____

* Present class placement: Regular Class: _____ Special Class (Specify Type): _____

* Kinds of special therapy or remedial work your child is currently receiving: _____

* Describe briefly any academic school problems: _____

* Rate your child's school experience related to behavior:

Good Average Poor

- Nursery School: _____
- Kindergarten: _____
- Current Grade: _____

* Please circle any of the following classroom problems your child's teacher describes as significant:

- Doesn't sit still in his/her seat
- Frequently gets up and walks around the classroom
- Shouts out – doesn't wait to be called upon
- Won't wait his or her turn
- Does not cooperate well in group activities
- Typically does better in an one-to-one relationship
- Doesn't respect the rights of others
- Doesn't pay attention during storytelling

Describe briefly any other classroom behavioral problems: _____

Peer Relationships:

- Does your child seek friendships with peers? _____ Do peers seek friendship with your child? _____
- Does your child play primarily with children his or her own age? (Circle One)
Or younger children? _____ Or older children? _____
- Describe briefly any problems your child may have with peers: _____

Interests and Accomplishments:

- What are you child's main hobbies, interests, and enjoyments? _____
- What are your child's areas of greatest accomplishments? _____
- What does your child like doing least? _____

Medical History: If your child's medical history includes any of the following, please note the age when the incident or illness occurred and other pertinent information.

- Childhood diseases (describe any complications): _____
- Operations: _____
- Hospitalizations for illness(es) other than operations: _____
- Head Injuries: _____
 With unconsciousness _____ Without unconsciousness _____
- Convulsions: _____ With fever _____ Without fever _____
- Coma: _____
- Meningitis or Encephalitis: _____
- Immunization Reactions: _____
- Persistent High Fevers: _____ Highest Temperature Recorded: _____
- Eye Problems: _____
- Ear Problems: _____
- Poisoning: _____

Present Medical Status:

- Present height: _____ Present weight: _____
- Present illness(es) for which child is being treated: _____
- Medications child is taking on an ongoing basis: _____

Trauma History:

Has the client been exposed to a traumatic event (s), including physical, sexual or emotional/verbal abuse, that involved actual or threatened serious psychological or physical injury to him/her or others close to the client?

Yes _____ No _____ If yes, specify the dates, frequency and duration of the trauma:

If yes, was the child's response a disorganized or agitated one? Yes _____ No: _____

Family History of the Biological Mother of the Child:

- Current Age: _____
- Age at the time of pregnancy with patient: _____
- Number of Previous Pregnancies: _____
- Number of Spontaneous Abortions (Miscarriages): _____
- Number of Induced Abortions: _____
- School: Highest Grade Completed: _____ Grades Repeated: _____
- Psychological Problems (Specify): _____
- Learning Problems (Specify): _____
- Behavioral Problems (Specify): _____
- Medical Problems (Specify): _____
- Have any of your blood relatives (not including patient and siblings) ever had problems similar to those your child has? If so, describe: _____

Family History of the Biological Father of the Child:

- Current Age: _____
- Sterility Problems (Specify): _____
- School: Highest Grade Completed: _____ Grades Repeated: _____
- Psychological Problems (Specify): _____
- Learning Problems (Specify): _____
- Behavioral Problems (Specify): _____
- Medical Problems (Specify): _____
- Have any of your blood relatives (not including patient and siblings) ever had problems similar to those your child has? If so, describe: _____

Siblings of the Child:

| | Name | Age | Psychoeducational or Medical Problems |
|----|-------|-------|---------------------------------------|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ |

Other Professionals Consulted With Regarding Child's Problems:

| | Name | Phone | Address |
|----|-------|-------|---------|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |

Please use the remainder of this page to write any additional comments you wish to make regarding your child's difficulties: _____

**Thank you for answering these questions.
 Your answers are most valuable in understanding your child.
 We look forward to seeing you.**