ITS Integrated Therapy Solutions

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Office Use: _____
Last Name: _____
Evaluation Date: _____
Evaluation Time: _____

CONFIDENTIAL PERSONAL HISTORY FOR CHILDREN AND YOUND ADULTS

CHILD/FAMILY HISTORY

Today's Date: _____

Child's Name: _____ Birthdate: _____/____/____ Age:____
Last Name First Name Nickname, if any

Address: _____ School: _____

_____ Grade: _____

Home Phone Number: _____ Sex: ☐ Female ☐ Male

Mother's Address: _____ Father's Address: _____

_____ _____

_____ _____

Home Phone #: _____ Home Phone #: _____

Cell Phone #: _____ Cell Phone #: _____

Email: _____ Email: _____

Languages spoken in the Home: _____

Primary Language of Child: _____

Questionnaire completed by: _____ Date: _____/_____/_____

REFERRAL INFORMATION:

Referred By: _____ Phone #: _____
Family, Regional Center, School District, Physician, Other Professional

Adress: _____
Street Address City State Zip

Please describe the reason(s) for your interest in this center: _____

May we send a thank you letter to your referral source? ☐ Yes ☐ No

Integrated Therapy Solutions has my permission to send a thank you letter to my referral source indicating that my child has been seen for an evaluation. No other information will be released without written consent.

Parent or Guardian: _____ Date: _____/_____/_____

RESPONSIBLE PARTY CONTACT INFORMATION:

Responsible Party/ Parties & Relationship(s) to Child: _____

Child Lives with: _____

Responsible Party Contact Information:

Name: _____ Telephone #: (____)_____ (____) _____
Home Work

Address: _____
Street Address City State Zip

Cell #: (_____) _____ Fax #: (_____) _____ E-Mail: _____

Marital Status of Parents: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Other: _____

FAMILY MEMBERS

	Age	Sex	Adopted	Education/Occupation	Handedness
Father: _____	_____	_____	Yes No	_____	R L
Mother: _____	_____	_____	Yes No	_____	R L
Stepfather: _____	_____	_____	Yes No	_____	R L
Stepmother: _____	_____	_____	Yes No	_____	R L
Children: _____	_____	_____	Yes No	_____	R L
_____	_____	_____	Yes No	_____	R L
_____	_____	_____	Yes No	_____	R L
_____	_____	_____	Yes No	_____	R L

Any Others Living at Home? _____
Name(s), Relationship(s)

Any Other Caregivers: _____
(daycare providers, regular babysitters, nanny, family, etc.)

Is there a history in the family of speech, language or learning disabilities of any kind, including hyperactivity or Attention Deficit Disorder? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

Has your child previously been diagnosed with a particular condition that would affect his or her speech, language, or auditory skills? (such as Down Syndrome, PDD, Cerebral Palsy, Hearing Impairment, Ear Infections etc.): _____

_____

_____

What are your child's favorite activities and games?: _____

_____

DEVELOPMENTAL HISTORY

Prenatal

Please check if the child's mother experienced any of the following health problems during her pregnancy (please comment where appropriate):

☐ Excessive nausea/vomiting	☐ Premature contractions	☐ Heart trouble pneumonia/flu
☐ Rh incompatibility	☐ High blood pressure	☐ Excessive weight gain
☐ Anemia	☐ Thyroid disease	☐ Weight gain < 10lbs.
☐ Asthma	☐ Diarrhea	☐ Special diet
☐ Diabetes	☐ Fever	☐ Toxemia (swelling)
☐ Bleeding/spotting	☐ German measles	☐ Unusual worries
☐ Kidney disease	☐ Measles	☐ Medications other than vitamins

☐ Illness/pneumonia/flu: _____

☐ Tiredness/fatigue: _____

☐ Confined to Bed: _____

☐ Accident: _____

☐ Exposure to smoking (self or others): _____

☐ Exposure to alcohol: _____

☐ Exposure to drugs (prescription, over-the-counter, or other): _____

Pregnancy (If child is adopted, turn to page 5)

What kind of experience was the pregnancy for both mother and father?

Father: _____

Mother: _____

More specifically:

	Yes	No	Comments
Was the pregnancy planned?	____	____	_____
Was hormone therapy used for conception?	____	____	_____
Were there complications?	____	____	_____
Shock	____	____	_____
Loss of a loved one	____	____	_____
Accident	____	____	_____
Other	____	____	_____
Was mother exposed to noise?	____	____	_____
Did mother talk much?	____	____	_____
Did mother sing?	____	____	_____
Was mother physically active?	____	____	_____
Did mother play a musical instrument	____	____	_____
Were any previous pregnancies complicated	____	____	_____

Was an ultrasound done prenatally? ☐ Yes ☐ No If yes:

How many times? What were the results?

Language(s) spoken during pregnancy? _____

In general, what kind of experience was the pregnancy for you? Please describe any outstanding events or difficulty conceiving (if applicable) _____

Labor and Delivery

Length of labor: _____ Apgar Score: _____

Birth Weight: _____ Birth Length: _____

	Yes	No	Comments
Full term?	____	____	_____
Pitocin Induction?	____	____	_____
Length of Labor?	____	____	_____
Forceps used?	____	____	_____
High forceps required?	____	____	_____
Suction required?	____	____	_____
Delivery Positon? (e.g. breech)	____	____	_____
Caesarian (reason)?	____	____	_____
Cried immediately?	____	____	_____
Required special treatment? (Blue Baby/Oxygen)	____	____	_____
Jaundice?	____	____	_____
Other Complication?	____	____	_____
Did the newborn have immediate physical contact with the mother?	____	____	_____
Was there a positive bonding experience between mother and newborn at birth?	____	____	_____
Was the newborn breastfed immediately?	____	____	_____
Describe any separations from mother during first days of life?	____	____	_____
Did mother experience any post-partum depression?	____	____	_____

Adoption *(Complete only if appropriate)*

Child's age at adoption: _____ Is your child aware of the adoption? ☐ Yes ☐ No

Describe the circumstances surrounding the adoption and any information about the birth parents.

Prior foster homes: _____

Physical appearance: _____

Response to new home: _____

Infancy/Childhood

Please describe in detail the **first two years** of the child's life:
What type of baby was he/she? (feeding, sleeping, activity level?_____

Was he/she fussy, happy, etc.? _____

If colicky, how long and how severe?_____

If your child was difficult to calm, what were the most successful methods? _____

Did and outstanding events occur? _____

What were reactions to immunizations? _____

Was child exposed to any toxins? _____

	Yes	No	Comments
Breastfed?	____	____	Untill what age?: _____
Toilet Trained?	____	____	At what age?: _____
Thumb sucking?	____	____	Until what age?: _____
Extended separations during first two years? (over 3 days)	____	____	_____
Specific health problems during this period?	____	____	_____
Feeding or sleeping problems?	____	____	_____
Did child use pacifier?	____	____	Until what age?: _____
Does child use sippy cup?	____	____	Until what age?: _____

Developmental Milestones

Did you find the child's early motor development (e.g., walking, talking, toilet training, etc.) to be:

☐ Early ☐ Average ☐ Late

Please indicate when the child first did the following:

Sat alone: ____months. Said first word(s): _____months. Walked without holding: _____months.

Crawled: _____months. Used 2-3 word phrases: _____months. Used sentences: _____months.

Did your child babble and coo? ☐ Yes ☐ No What age did they start please explain: _____

_____

Was your child a "quiet baby"? ☐ Yes ☐ No If yes, please explain: _____

_____

Health

How would you describe the child's health during his/her first two years? _____

_____

How would you describe the child's health since age two? _____

_____

What date was the child's most recent medical check-up? _____ Doctor: _____

Is your child in good general health at the present time? ☐ Yes ☐ No Please explain:_____

Does the child have a history of the following:

	Yes	No	Age	Comments
Respiratory problems?	____	____	_____	_____
High fever?	____	____	_____	_____
Meningitis?	____	____	_____	_____
Ear infections?	____	____	_____	_____
Adenoid problems?	____	____	_____	_____
Frequent colds?	____	____	_____	_____
Strep throat?	____	____	_____	_____
Allergies?	____	____	_____	_____
Congestion?	____	____	_____	_____
Asthma?	____	____	_____	_____
Bronchitis?	____	____	_____	_____
Other Complication?	____	____	_____	_____
Autism/PDD/Asperger's?	____	____	_____	_____
Seizures?	____	____	_____	_____
Convulsions?	____	____	_____	_____
Ear Infections?	____	____	_____	_____
Epilepsy?	____	____	_____	_____
Enuresis (bedwetting, urinating into clothing)?	____	____	_____	_____
Encopresis (repeated passage of feces into inappropriate places)?	____	____	_____	_____
Fitful Sleep?	____	____	_____	_____
Nightmares?	____	____	_____	_____
Nail Biting?	____	____	_____	_____
Gastro-Intestinal problems?	____	____	_____	_____
Injuries?	____	____	_____	_____
Multi-system sensory disorder?	____	____	_____	_____
Surgeries?	____	____	_____	_____
Skin problems?	____	____	_____	_____

Is your child currently taking any prescribed medication? How much and for what condition? _____

_____

_____

Has medication been prescribed in the past to help your child's *mood* or *behavior*? _____

_____

Has he/she ever been hospitalized? ☐ Yes ☐ No If yes, please explain reasons: _____

_____

Has he/she ever had a serious accident/injury? ☐ Yes ☐ No If yes, please explain: _____

_____

Are there any other medical illnesses or conditions which have been diagnosed? _____

_____

Visual Development

Does the child have vision/eyesight problems? ☐ Yes ☐ No If yes, please explain: _____

_____

Has the child had an eye exam? ☐ Yes ☐ No Date of test: _____

If yes, what were the results? _____ Dr. _____

Does the child:

Wear Glasses?	☐ Yes	☐ No
Appear to be sensitive to light?	☐ Yes	☐ No
Explore objects using peripheral vision?	☐ Yes	☐ No
Resist having vision occluded?	☐ Yes	☐ No
Squint or close one eye when looking at things?	☐ Yes	☐ No
Appear not to notice things in their environment or focus on minute detail?	☐ Yes	☐ No
Have an attraction to spinning objects or vertical and horizontal lines?	☐ Yes	☐ No
Get over-excited when confronted with variety of stimuli?	☐ Yes	☐ No
Discriminate colors, shapes?	☐ Yes	☐ No

Has the child had any experience with vision training in the past? If so, what, when, and where?_____

_____

_____

Previous Evaluations and Treatment

Has your child been evaluated for a speech, language, or auditory problem in the past? ☐ Yes ☐ No

If yes, when? _____

If you were unhappy with those services, what would you like us to do differently? _____

_____

_____

Has your child been evaluated or treated by a physical or occupational therapist? ☐ Yes ☐ No

If yes, when? _____

Result: _____

Has your child been evaluated by a psychologist or learning consultant? ☐ Yes ☐ No

If yes, when? _____

Result: _____

Has your child been evaluated by a neurologist? ☐ Yes ☐ No

If yes, when? _____

Result: _____

Has your child been evaluated by an ear-nose-throat physician? ☐ Yes ☐ No

If yes, when? _____

Result: _____

Have there been any specific events of traumas linked with the onset of your child's difficulties? _____

_____

_____

Is your marital situation stable and positive at this time? _____

_____

_____

What, if any, stresses are affecting your family at this time? _____

_____

_____

Are there other individuals or family members living at home?_____

_____

Social Interaction and Behavior (check all that apply)

☐ Typical for age ☐ Quiet ☐ Outgoing

☐ Likes to point out things to show you.

☐ Does not play "pretend" or imaginary games well.

☐ Usually doesn't acknowledge people (waving, saying "hi") when they enter unless prompted.

☐ Usually doesn't acknowledge people when they leave (waving, saying "bye") unless prompted.

☐ Is unusually active for his/her age.

☐ Tends to prefer playing alone.

☐ Prefers to play with younger children.

☐ Has a shorter attention span than you expect for his/her age.

☐ Avoids eye contact.

☐ Doesn't seem to know *how* to interact with other children (although wants to).

☐ Is unusually irritable in noisy or crowded places such as malls, parties, etc.

☐ Often repeats phrases heard out of context.

☐ Doesn't respond to his/her name consistently.

☐ Has periodic screaming fits (beyond typical tantrums).

☐ Short temper.

☐ Can be violent or unusually physically aggressive (beyond typical childhood outbursts).

Any other behavior or emotional issues? _____

_____

Auditory Development

Does the child have a hearing problem? ☐ Yes ☐ No If yes, please describe: _____

_____

Has the child had his/her hearing tested? ☐ Yes ☐ No Date tested: _____

If yes, what were the results? _____

Did the child have any ear problems ***before the age of 2*** (e.g., ear infections, ear aches, draining ears, fluid behind the ears, medications taken for ears, etc.)? _____

_____

Approximately how many ear problems/infections has the child had in his/her life? _____

Were/are they: ☐ Mild ☐ Moderate ☐ Severe

Did the child have Ventilation tubes? ☐ Yes ☐ No If yes, Dates: _____

Does the child have a diagnosed hearing loss? ☐ Yes ☐ No Please explain: _____

_____

Have you or others ever thought your child was deaf? _____

Has the child had any training with sound stimulation, auditory processing training in the past? If so, what, when, and where? _____

_____

_____

Does the child:

☐ Yes ☐ No Hear things before you hear them?

☐ Yes ☐ No Seem overly sensitive to sound?

☐ Yes ☐ No Become frightened by certain sounds, such as certain machinery, toys, voices, or other things? If so, what are the sounds? _____

☐ Yes ☐ No Miss some sounds?

☐ Yes ☐ No Seem confused about the direction of sounds?

☐ Yes ☐ No Like to make loud noises?

☐ Yes ☐ No Become easily distracted?

☐ Yes ☐ No Tend to "tune you out" when there is background noise present, such as a dishwasher or TV?

☐ Yes ☐ No Need to have instructions repeated frequently?

☐ Yes ☐ No Often say, "What"? or "Huh"?

☐ Yes ☐ No Often fail to pay attention when being spoken to?

☐ Yes ☐ No Often need an unusually long amount of time to process verbal information before responding?

☐ Yes ☐ No Often have difficulty remembering what is said?

☐ Yes ☐ No Frequently lose his/her concentration?

☐ Yes ☐ No Have others (i.e., teachers, therapists) who work with your child commented on his/her listening skills? Explain: _____

Are you concerned that your child may have Attention Deficit Disorder? (if not already diagnosed): _____

_____

Speech and Language Development

How would you describe your child's speech and language development:

☐ Normal ☐ Delayed ☐ Advanced First words at age: _____

Did your child begin speaking in single words, then two, then a sentence? OR Did your child not talk for a long while, then all of a sudden speak in complete sentences? Explain: _____

_____

Describe the child's speech and language and any problems: _____

_____

_____

Does your child have difficulty pronouncing certain sounds? ☐ Yes ☐ No If yes please list if you can: _____

_____

Does your child mumble often? ☐ Yes ☐ No If yes, please explain: _____

_____

Does your child seem inhibited by his or her speech difficulty? ☐ Yes ☐ No If yes, please explain: _____

_____

Does your child often reduce or transpose the number of syllables in a word? (ex: "Indiana" pronounced as "danna"):

_____

_____

If school age, does your child write words with the same patterns exhibited in their speech? (ex: child writes "wabbit" instead of "rabbit", or "fink" instead of "think") ☐ Yes ☐ No If yes, please explain: _____

_____

Expressive Language

For children ages 2-4 only

Is your child talking yet? ☐ Yes ☐ No _____

Does your child use a lot of gestures to help communicate? ☐ Yes ☐ No _____

Does your child seem frustrated by his/her difficulty talking? ☐ Yes ☐ No _____

Does your child nod his/her head for yes/no questions? ☐ Yes ☐ No _____

Does your child repeat (echo) the question instead of answering it? ☐ Yes ☐ No _____

Does your child seem disinterested in talking? ☐ Yes ☐ No _____

Does your child seem overly interested in one particular thing (such as trains?) ☐ Yes ☐ No _____

_____

Does your child seem to be exceptionally good at learning letters, reading? ☐ Yes ☐ No _____

_____

Does your child seem to be exceptionally good at doing puzzles? ☐ Yes ☐ No _____

_____

Does your child seem to be exceptionally good or interested in computers? ☐ Yes ☐ No _____

_____

For children 5 and up only

Does your child tend to "ramble on" (out of sequence) when retelling events or explaining so that it is difficult to follow (that is unusual for hi/her age)? ☐ Yes ☐ No _____

_____

Does your child use an inordinate amount of "uhs" and "ums" in his/her conversational speech? ☐ Yes ☐ No ___

_____

Does your child use vague language frequently, so that it is difficult to follow at times? (such as "She put the thing on that other place") ☐ Yes ☐ No _____

_____

Does your child tend to confuse positional words, such as "left/right"? ☐ Yes ☐ No _____

_____

Does your child have difficulty speaking in complete sentences with normal grammar? ☐ Yes ☐ No _____

_____

Does your child tend to leave off the ends of words? ☐ Yes ☐ No _____

_____

Does your child forget names of familiar things? (May use words such as "whatchamacallit" and get frustrated)
☐ Yes ☐ No _____

Does your child have difficulty "getting started" with open-ended questions (such as "Tell me about the party") yet can answer direct questions about it? (such as "Was Jacob at the party?") ☐ Yes ☐ No _____

_____

Motor Development

How would you describe your child's motor development:

☐ Normal ☐ Delayed ☐ Advanced

At what age did you child: Crawl _____ Walk _____

Does your child participate in sports? ☐ Yes ☐ No Name: _____

Hand Dominance: ☐ Right ☐ Left Age established: _____

Does the child: *Muscle Tone*

☐ Yes ☐ No Have a grasp of a crayon/pencil that is less mature than peers?

☐ Yes ☐ No Seem weaker or stronger than normal? _____

☐ Yes ☐ No Have any diagnosed muscle pathology? (e.g., spasticity, flaccidity, rigidity)

Does the child: *Coordination*

☐ Yes ☐ No Have difficulty manipulating small objects easily?

☐ Yes ☐ No Seem accident prone?

☐ Yes ☐ No Eat in a sloppy manner?

☐ Yes ☐ No Have difficulty dressing and/or fastening clothes? Explain: _____

☐ Yes ☐ No Have a consistent hand dominance? Explain: _____

☐ Yes ☐ No Neglect one side of the body, or seem unaware of it? Explain: _____

☐ Yes ☐ No Have trouble riding a tricycle and/or bicycle?

☐ Yes ☐ No Have trouble playing on playground equipment?

Does the child: *Sensory – Tactile Sensation*

☐ Yes ☐ No Object to being touched/cuddled? Explain: _____

☐ Yes ☐ No React negatively to the feel of new clothes?

☐ Yes ☐ No Prefer certain textures of clothing?

☐ Yes ☐ No Dislike having hair and/or face washed?

☐ Yes ☐ No Dislike having teeth brushed and/or nails clipped? Explain: _____

☐ Yes ☐ No Avoid certain textures of food?

☐ Yes ☐ No Isolate self from other children? Explain: _____

Does the child: *Sensory – Vestibular Sensation*

☐ Yes ☐ No Seem fearful in space (i.e., going up/down stairs) Explain: _____

☐ Yes ☐ No Appear clumsy, often bumps into things or others, falls down? Explain: _____

☐ Yes ☐ No Climb well but is cautious of others bumping into him? Explain: _____

☐ Yes ☐ No Spin self? Explain: _____

☐ Yes ☐ No Walk upstairs always leading with same foot? Explain: _____

Does the child: *Sensory – Olfactory Sensation*

☐ Yes ☐ No Explore the environment with smell? Explain: _____

☐ Yes ☐ No Discriminate odors poorly?

☐ Yes ☐ No React defensively to smell? Explain: _____

Does the child: *Sensory – Gustatory Sensation*

☐ Yes ☐ No Act as though all food tastes the same? Explain: _____

☐ Yes ☐ No Open to tasting new foods?

☐ Yes ☐ No Dislike foods of a certain texture or multiple textures? Explain: _____

☐ Yes ☐ No Avoid or crave certain temperatures of food? Explain: _____

Oral Motor Development

How would you describe your child's chewing and swallowing? (check all that apply)

☐ Typical for his/her age.

☐ Messy for his/her age.

☐ Chokes at times more than I would expect.

☐ Has a very limited number of foods he or she will eat. Please list favorites: _____

☐ Avoids hard and crunchy foods.

☐ Stuffs lots of food into his/her mouth at once.

☐ Drools when eating.

☐ Drools at rest.

Does your child resist getting his/her teeth brushed? ☐ Yes ☐ No If yes, please explain: _____

_____

Does your child resist getting his/her face washed? ☐ Yes ☐ No If yes, please explain: _____

_____

Are you concerned about your child's nutrition as a result of his or her feeding difficulties? Please explain: _____

_____

EDUCATIONAL HISTORY

In general, how would you describe your child's experience/learning at school from kindergarten to the present time?

_____

_____

_____

How did your child adapt to the first day (s) at school or pre-school

☐ Mostly positive ☐ Mixed ☐ Mostly negative

How old was he/she? _____

How much time did he/she attend? _____ per week.

Please give us more detailed information about any difficulties your child encoundtered in school beginning with the earliest experience.

Initial school adjustment: _____

_____

Pre-school/Daycare: _____

_____

Primary (K – Grade 3): _____

_____

Junior (Grades 4 – 6): _____

_____

Intermediate (Grades 7 – 8): _____

_____

High School (Grades 9 – 12): _____

_____

Has there been remedial help given outside the school system? ☐ Yes ☐ No If yes, describe: _____

_____

_____

Can he/she listen to more than one conversation at once? ☐ Yes ☐ No Explain: _____

_____

Does he/she recall how things look? ☐ Yes ☐ No Explain: _____

_____

Does he/she like movies and museums? ☐ Yes ☐ No Explain: _____

_____

Does he/she like dancing and sports? ☐ Yes ☐ No Explain: _____

_____

Does he/she take risks or learn only when very comfortable? ☐ Yes ☐ No Explain: _____

_____

More Specifically:

Did the child attend preschool? ☐ Yes ☐ No If yes, where? _____

Where does your child presently attend school? (What grade/class designation?) _____

_____

What hours/days does your child attend school? _____

Has the child ever repeated a grade? ☐ Yes ☐ No If yes, which grade(s)? _____

Has the child ever participated in a special education evaluation? ☐ Yes ☐ No If yes, when? _____

Has the school system made an Individual Education Plan (IEP) for the child? ☐ Yes ☐ No Explain: _____

_____

Date of last IEP: _____ School District: _____

Has the child been given an IQ score or level of retardation? ☐ Yes ☐ No _____

_____

If yes, please describe when, where, by whom & results

_____

Please list the schools that your child has attended, including his/her current school:

School/Location *Grade*

_____

_____

_____

_____

Has your child ever attended:

	When?	Where?
☐ Special Education Classes		
☐ Remedial Classes		
☐ Tutoring/Remedial Help		
☐ Speech/Language Therapy		
☐ Physical/Occupational Therapy		
☐ Counseling/Therapy		

What are your child's current **grades** in school? _____

School Issues

If your child is presently attending school, please check off the areas in which he or she is experiencing difficulty:

☐ Learning the names of letters.

☐ Printing the letters.

☐ Spacing the letters and words on the page.

☐ Remembering the sounds the letters make.

☐ Putting the letters together to sound out a word.

☐ Comprehending information they read.

☐ Following directions from the teacher.

☐ Spelling.

☐ Writing spelling words in sentences that are not dull and repetitive.

☐ Keeping his/her attention on the teacher.

☐ Getting homework completed without a great deal of help.

☐ Sitting in the chair at school without fidgeting or falling off.

☐ Gripping the pencil without breaking the pencil tip or getting sore.

☐ Copying letters or words from the blackboard onto his/her paper.

☐ Copying anything from a book or paper onto another paper.

☐ Forgetting assignments/books at school.

☐ Learning math facts.

☐ Understanding math word problems.

☐ Learning and remembering vocabulary for classes such as Social Studies/Science.

☐ Pronouncing and learning new multi-syllabic words (long words).

☐ Remembering things people say.

☐ Putting things in order (for example the sequence of directions gets mixed up, the order of the day of the week, months of the year, phone number, etc.

☐ Misunderstanding what to do on projects or homework assignments.

☐ Taking tests orally.

☐ Answering fill-in-the blank tests.

☐ Answering open-ended essay tests.

Parent Observations/Comments: _____

_____

_____

BEHAVIOR/CHARACTER

How would you describe your child? _____

_____

What kind of interests and activities does your child have? (hobbies, sports, clubs). Please list them in order of preference beginning with the favorite activity. _____

_____

_____

How would you describe your child's social adjustment?
With peers? _____

_____

With adults? _____

_____

Please describe the child's behaviors that are of concern at home, at school, and/or in the community. What was the age of onset and the age when you became concerned?

_____

_____

_____

Please tell us about the child's behavior and character. What kind of person is he/she?

_____

_____

Strengths	*Weaknesses*
_____	_____
_____	_____
_____	_____

Please check any behavior characteristics that apply to your child:

☐ Aggression	☐ Low self-esteem	☐ Short attention span	☐ Unusual fears
☐ Manipulative	☐ Sleep problems	☐ Depression	☐ Nail biting
☐ Frequent crying	☐ Impulsive	☐ Nightmares	☐ Truancy
☐ Noncompliant	☐ Perfectionist	☐ Moodiness	☐ Substance Abuse
☐ Tics/Nervous Gestures	☐ Poor motivation/Apathy	☐ Bedwetting/Toileting problems	
☐ Hyperactivity/Attention-Deficit Disorder		☐ Unkempt personal appearance	

For any behavior characteristic that you checked, please explain and provide specific examples. This information assists us in better understanding the child's personality and needs.

_____

_____

_____

If your child is currently receiving speech-language and/or Occupational/Physical services through the public schools, would you like us to work in conjunction with the school speech-language pathologist and/or occupational/physical therapist to coordinate the therapy methods? ☐ Yes ☐ No

Please list the speech-language pathologist's, Occupational Therapist, Physical Therapist names, school address & phone number:

_____

_____

Did you decline special education services or evaluations that were offered in the public schools for your child?

☐ Yes ☐ No Please explain: _____

_____

_____

For evaluations, may I contact your child's teacher(s) at school for further information as it relates to this assessment?

☐ **No**

☐ **Yes**, ***please speak to: (include phone numbers)***

_____

_____

_____

Parent Signature _____ Date _____

Please check which areas are of concern to you:

☐ Attention

☐ Focusing

☐ Following Directions

☐ Understanding what is being said

☐ Behavior

☐ Speech (describe): _____

☐ Language (describe): _____

☐ Tantrums

☐ Motor Skills (describe): _____

☐ Reading & Spelling

☐ Learning

☐ Social Skills

☐ Transitions and Flexibility

☐ Sleep Patterns

☐ Food/Eating Habits

☐ Other (describe): _____

Please check areas you would like to see improved:

☐ Listening
☐ Attention
☐ Behavior
☐ Reading & Spelling
☐ Social & Behavioral Skills
☐ Motor Skills
☐ Learning
☐ Speaking
☐ Critical Thinking
☐ Organization
☐ Memory

GOALS

What are your goals for your child's program? Please be as specific as possible:

1. _____
   _____
   _____
2. _____
   _____
   _____
3. _____
   _____
   _____
4. _____
   _____
   _____