LESLIE A. STUART, PSY.D.
Licensed Psychologist

BACKGROUND INFORMATION:

Child's Name: ____

Date of Birth: ______________ Chronological Age: ___________________

School: ___________________________________ Grade ________

Parent 1 Name: ____

Address: ____

____

Telephone Number: ________________Email________________________

Occupation: ____

Parent 2 Name: ____

Address: ____

____

Telephone Number: ________________Email________________________

Occupation: ____

Step-Parent/Guardian Name: ____________________________________

Address: ____

____

Telephone Number: ________________Email________________________

Marital Status of Parents: Single ___ Married ____Divorced ___ Widowed ___ Other ___

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REFERRAL INFORMATION:

Referred By: ____

Describe the reasons you are requesting this evaluation of your child. If possible, list specific questions for which answers are sought.

Language(s) spoken if not English: ______________________________

List all people now living in your household, then draw a line and list others who have lived with the child. (Please note dates)

NAME	RELATIONSHIP TO CHILD	AGE	HIGHEST SCHOOL GRADE ATTENDED	OCCUPATION

Please indicate if any children in the household were adopted and date of any previous marriages, divorces, or remarriages of Parents. Describe any custody arrangements or other living arrangements/situations. Describe any deaths in the immediate family. Note any unusual family circumstances.

Pediatrician: ____

Address: ____

____

Telephone: ____

Permission to speak with pediatrician: Yes _________ No _________

PREGNANCY AND BIRTH HISTORY:

Describe any complications that occurred during pregnancy (i.e., mother's pregnancy, early childhood, etc.)

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____

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Describe any complications that occurred during delivery (i.e., prematurity, postmaturity, length of labor, special procedures, etc.)

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____

____

Birth weight? ________________ How long after birth did you take your baby home? __________

EARLY TEMPERAMENT:

Describe the child's temperament during the first 6 months (i.e., sleep patterns, colic, eating patterns)

____

____

DEVELOPMENTAL HISTORY: (Note the approximate ages of the following:)

Sitting unsupported: ____________________ Walking alone: _________________________

Using single words: _____________________ Using two or more words together: __________

Toileting: Urine daytime: ___________________ Nighttime: ___________________

Bowel daytime: __________________ Nighttime: ___________________

Which hand does your child prefer? Right ______ Left ______ Age established _________

MEDICAL HISTORY:

List sicknesses (i.e., frequent ear infections, operations, and injuries). Include the age when they occurred and severity. Please pay special attention to head injuries, any loss of consciousness, convulsing, or very high fever.

____

____

____

____

Did anyone in your immediate family or close relative have any of the following?

Nervous tics?	Yes ____	No ____	Who? _______________________
Seizures (epilepsy)?	Yes ____	No ____	Who? _______________________
Emotional problems?	Yes ____	No ____	Who? _______________________
Hyperactivity?	Yes ____	No ____	Who? _______________________
Learning problems?	Yes ____	No ____	Who? _______________________
Language problems?	Yes ____	No ____	Who? _______________________
Mental retardation?	Yes ____	No ____	Who? _______________________
Left-handedness?	Yes ____	No ____	Who? _______________________
Similar problems to child?	Yes ____	No ____	Who? _______________________

Does any disease run in the family? If so, what? ____________________________________

Past medications: (indicate dosage, physician, and reason it was taken):

___

___

___

___

Current medications:

Medicine: ________ Dose: ____ Purpose: _________________ Prescribed By: ____________________

Medicine: ________ Dose: ____ Purpose: _________________ Prescribed By: ____________________

Medicine: ________ Dose: ____ Purpose: _________________ Prescribed By: ____________________

Medicine: ________ Dose: ____ Purpose: _________________ Prescribed By: ____________________

Has your child's vision been examined?_________________Date: ______________________________

If so, by whom? ____

Results: ____

Has your child's hearing been examined?________________Date: _____________________________

If so, by whom? ____

Results: ____

Other special medical tests (EEG, CAT Scan, MRI):

Name of Test: _______________________________ Date: ______________________

Purpose/Results: ____

Previous psychological or neurological evaluations: (List names, addresses, dates, and any pertinent reports). **Please provide a copy of the written report.**

___

___

Psychiatric hospitalizations: (List names, addresses, dates, etc.) ______________________________

____

Psychotherapy: (List names, addresses, dates, etc.) ____

____

<u>SOCIAL-EMOTIONAL/BEHAVIORAL HISTORY</u>:

List your child's personality characteristics, both positive and negative:

____

____

____

____

Note any particular behavioral concerns (i.e., eating habits, sleeping patterns, level of activity, sibling relationships, peer relationships, moodiness, attending difficulties, destructiveness, unusual habits, fears, tenseness, etc.):

____

____

____

____

Current discipline techniques:

____

____

____

____

Who disciplines?

Do parents agree on how to discipline? ______

How does your child respond to discipline? ______

SCHOOL HISTORY:

List previous schools attended with grades and dates (include nursery and preschools):

Describe any learning/behavioral/social difficulties at school:

<u>Public School services</u>: (List date placed and services received)

Early Intervention program:

TAG/Discovery (Gifted Program):

Learning Disability/O.H.I./Student Support Team:

Speech and language services:

Occupational therapy services:

<u>Private services</u>: (List date placed, services received, and phone number)

Tutoring: ____

____

Speech/language therapy: ____

____

Occupational therapy: ____

____

If your child attends a private school, do they participate in any specialized programs through the school for learning support? If so, describe:

____

____

____

____

Has your child ever repeated a grade? _________ If so, when? ___________________________

What was the reason? ____

Attach a copy of the most recent report card and standardized test scores:

____

____

You will receive copies of your child's report to distribute to various school personnel and physicians. If you wish a report of findings to be sent directly from our office to a physician, school, or other child agency, please indicate to whom and sign attached release of information form:

____

____

Please feel free to add any additional comments that you feel will be helpful on the attached page.

I very much appreciate the trouble to which you have gone in filling out this questionnaire. Please add any additional comments on the next page.

Signed: ______________________________ Date: ______________________

ADDITIONAL COMMENTS: