*This is a form designed to collect information about your child. While some of these questions are personal in nature the information can help determine what factors may impact his or her learning. This information will be used in your child’s evaluation report, but will only be shared with those who have an educational need to know.*

|  |  |  |
| --- | --- | --- |
| **Student Name**  | **Birthday:** | **Age:**  |
| **School:**  | **Grade:**  | **Date:**  |
| **Person completing this form:**  | **Relationship to student:**  |
| **Best way to contact you (email and/or phone):**  |

What concerns you most about your child?

What are your child’s strengths (click all that apply)?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  Memory | [ ]  Reading | [ ]  Math | [ ]  Science  | [ ]  Social Studies |
| [ ]  Spelling | [ ]  Handwriting | [ ]  Writing | [ ]  Organization | [ ]  Perseverance |
| [ ]  Sports | [ ]  Leadership | [ ]  Social Skills | [ ]  Art | [ ]  Music  |
| [ ]  Theater | [ ]  Helper | [ ]  Sense of humor | [ ]  Kindness | [ ]  None |

Please click any concerns you have regarding your child:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  Basic Reading Skills | [ ]  Reading Fluency  | [ ]  Math Problem Solving | [ ]  Basic Math Skills | [ ]  Reading Comprehension |
| [ ]  Writing | [ ]  Handwriting | [ ]  Spelling | [ ]  Organization | [ ]  Speech/Communication |
| [ ]  Anxiety | [ ]  Depression | [ ]  Eating Disorder | [ ]  Fears | [ ]  Lies/Dishonest |
| [ ]  Bullying | [ ]  Aggression | [ ]  Autism  | [ ]  Obsessions | [ ]  Steals |
| [ ]  hyperactive/Impulsive | [ ]  Drug/Alcohol Use | [ ]  Lacks motivation | [ ]  Lacks self-control | [ ]  Other: Click or tap here to enter text. |

What would you like to see happen for your child?

**General Information**

Who is/are the child’s legal guardians?

If parents are divorced or separated, who has custody?

How often does this child see the other parent?

When did the separate or divorce occur?

Primary language spoke in the home: Other Languages:

 Which language is preferred by the child: Reading/Writing

Speaking

Who lives at home with your child (include adults and children):

|  |  |  |
| --- | --- | --- |
| **Name** | **Age** | **Relationship to student**  |
|  |  |  |
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|  |  |  |

Have any other relatives experienced problems similar to the ones your child is experience, if so please describe:

Is there a family history of mental health concerns, if so please describe?

Have there been any recent changes in your family situation (moves, deaths, divorce, etc.)?

Have there been any recent family stressors (financial, emotional, etc.)?

**Developmental History**

Were there any problems before, during, or immediately following birth, if so please explain:

Please click any conditions the child’s mother suffered from while pregnant:

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Excessive Swelling | [ ]  Flu | [ ]  Toxemia | [ ]  Anemia |
| [ ]  High Blood Pressure | [ ]  Abnormal Weight Gain  | [ ]  Excessive Vomiting | [ ]  Other:  |

Was the mother under a doctor’s care (click)? [ ]  No [ ]  Yes

Do you have reason to suspect any of the following were used during pregnancy (click)?:

 Alcohol [ ]  No [ ] Yes Frequency:

 Cigarettes [ ]  No [ ]  Yes Frequency:

 Other Drugs: [ ]  No [ ]  Yes Frequency:

Please click any complications that occurred during birth:

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Infection | [ ]  Seizures | [ ]  Heat Problems | [ ]  Bone Problems |
| [ ]  Blood Transfusion | [ ]  Caesarean Delivery | [ ]  Jaundiced | [ ]  Other: Click or tap here to enter text. |

At what age did each of the following occur:

Walking

Toilet Trained

Talking

Does your child continue to have toileting accidents? [ ]  No [ ]  Yes, describe

Does your child’s coordination (motor control) appear to be normal? [ ]  No [ ]  Yes

 If no does the problem appear to be with:

[ ]  fine motor (pencil grasp, picking up small objects, etc.)

[ ]  gross motor (walking, catching, throwing, etc.)

Characteristics of your child’s temperament when he/she was an infant (click best answer):

Mood [ ]  Unhappy [ ]  Happy [ ]  Very happy

 Activity Level [ ]  Low [ ]  Average [ ]  Overly Active

 Attention Level [ ]  Low [ ]  Average [ ]  Very Good

 Ability to deal with change [ ]  Poor [ ]  Good [ ]  Very Good

 Ability to respond to new things [ ]  Poor [ ]  Good [ ]  Very Good

Characteristics of your child’s temperament when he/she was a toddler (click best answer):

Mood [ ]  Unhappy [ ]  Happy [ ]  Very happy

 Activity Level [ ]  Low [ ]  Average [ ]  Overly Active

 Attention Level [ ]  Low [ ]  Average [ ]  Very Good

 Ability to deal with change [ ]  Poor [ ]  Good [ ]  Very Good

 Ability to respond to new things [ ]  Poor [ ]  Good [ ]  Very Good

Did your child have any childhood illnesses, accidents, or hospitalizations (for example: measles, chicken pox, chronic ear infections, allergies, high fevers, seizures, head injuries, broken bones, surgeries, etc.)?

If you are not the child’s biological parent, how long has the child been in your custody?

Please explain any previous living/custodial situations (foster care, residential treatment facility, etc.):

**Current Health Information**

Is your child currently seeing a physician for a medical problem? If so please explain:

Is your child currently taking any medications? If yes, please list name, dosage (mg), how often:

|  |  |  |
| --- | --- | --- |
| Name | Dosage (mg) | How often (AM/PM) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Describe any side effects the medication(s) might have:

List any medications your child previously took for a long period of time:

Is your child receiving services from another agency including:

 Tutoring [ ]  No [ ]  Yes, where and how often:

 Counseling [ ]  No [ ]  Yes, where and how often:

 MHMR Services [ ]  No [ ]  Yes, where and how often:

 Probation Monitoring [ ]  No [ ]  Yes, where and how often:

 Speech Therapy [ ]  No [ ]  Yes, where and how often:

 Other: [ ]  No [ ]  Yes, where and how often:

Does your child have difficulty falling asleep at night? [ ]  No [ ]  Yes, please describe:

How many hours does your child typically sleep?

Has your child lost or gained a lot of weight during the last six months? [ ]  No [ ]  Yes, please describe:

Does your child require (click all that apply): [ ]  Glasses [ ]  Contact Lenses [ ]  Hearing Aid

Has your child ever been admitted to a residential care facility (Millwood, Sundance, Excel, etc.)? [ ]  No [ ]  Yes

 If yes, please list facility and dates:

|  |  |
| --- | --- |
| Name of facility  | Dates (admitted/discharged) |
|  |  |
|  |  |
|  |  |
|  | Click or tap here to enter text. |

Has your child ever had a neurological or psychological exam? [ ]  No [ ]  Yes, describe (when, where, why):

**Behavioral, Emotional, and Social History**

Describe your child’s behavior at home:

Please describe any behavioral concerns you have regarding your child:

 When do you see this behavior(s):

 How long does the behavior(s) last:

 How often does it occur:

 Have there been any recent changes in your child’s behavior? [ ]  No [ ]  Yes, please describe:

What are your child’s favorite activities at home (sports, hobbies, family activities)?

Does your child isolate him/herself from family and friends (does not play with friends or interact with family members)? [ ]  No [ ]  Yes, please describe:

Does your child appear withdrawn and not interested in age-appropriate activities (playing outside, video games, playing with friends, watching movies, etc.)? [ ]  No [ ]  Yes, please describe:

Do you know or suspect that someone may have abused or molested your child? [ ]  No [ ]  Yes, please describe:

Has your child witnessed violent acts (domestic violence, neighborhood fights/violence, etc)? [ ]  No [ ]  Yes, please describe:

Do you have any reason to believe your child is involved in gang activity? [ ]  No [ ]  Yes, please describe:

Has your child every talked about committing suicide or attempted suicide? [ ]  No [ ]  Yes, please describe:

Has your child ever threatened or tried to seriously injure or kill someone else? [ ]  No [ ]  Yes, please describe:

Do you use rewards and consequences with your child at home ? [ ]  No [ ]  Yes

|  |  |
| --- | --- |
| Rewards | Consequences |
|  |  |
|  |  |
|  |  |
|  |  |

 Are these effective? [ ]  No [ ]  Yes

**Educational History**

Please list any school your child has attended:

|  |  |  |
| --- | --- | --- |
| School Name | District | Grade(s) Attend |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Has your child ever been evaluated for special education services? [ ]  No [ ]  Yes, please describe (when/outcome):

Has your child ever been retained? [ ]  No [ ]  Yes, when:

Has your child ever been assigned to an alternative placement (JJAEP, DAEP, etc.)? [ ]  No [ ]  Yes, please describe:

Does your child express concerns about having problems with school? [ ]  No [ ]  Yes, please describe:

Is your child absent from school frequently? [ ]  No [ ]  Yes, why?

**Speech Therapy Information**

Has your child ever received Speech Therapy before? [ ]  No [ ]  Yes If so, where and for how long?

*\*\*Please provide any information you have from your child’s previous therapy (evaluation reports, progress notes, etc.) If you have speech concerns continue to complete this form. If you do not have speech concerns you may discontinue\*\**

How does your child usually communicate (gestures, single words, short phrases, sentences)?

At what age did you first notice your child’s speech difficulties?

What changes have you noticed since you first observed the problem?

Did the student’s previous teacher indicate any problems related to speech? [ ]  Yes [ ]  No [ ]  N/A

Do you think your child is concerned about his/her speech? [ ]  Yes [ ]  No

If Yes, please describe (Include information on their reactions to speech difficulties.):

Do you think your child’s speech is impacting his/her relationships with others ? [ ]  Yes [ ]  No

If Yes, please describe:

Additional information you would like to share: