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Personal Information (Child/Adolescent) – Learning Evaluation

Child's Name:_____ Today's Date: _____
Person completing form: _____ Role: _____ (i.e. mother, father)

Child Date of Birth: _____ Age: _____ SS#: _____
Child's Home Address: _____(city)_____ (state) _____ (zip) _____
Mother's Name: _____ Date of Birth: _____ Phone: _____
Mother's Address: _____(city)_____ (state) _____ (zip) _____
Mother's Employer: _____ Occupation: _____
Employer Address: _____ Work Phone: _____
Father's Name: _____ Date of Birth: _____ Phone: _____
Father's Address: _____ (city)_____ (state) _____ (zip) _____
Father's Employer: _____ Occupation: _____
Employer Address: _____ Work Phone: _____
Stepmother's Name: _____ Date of Birth: _____ Phone: _____
Stepmother's Address: _____(city)_____ (state) _____ (zip) _____
Stepmother's Employer: _____ Occupation: _____
Employer Address: _____ Work Phone: _____
Stepfather's Name: _____ Date of Birth: _____ Phone: _____
Stepfather's Address: _____ (city)_____ (state) _____ (zip) _____
Stepfather's Employer: _____ Occupation: _____
Employer Address: _____ Work Phone: _____

Other Family Members
Name: _____ M/F Date of Birth: _____ Where Living: _____
Name: _____ M/F Date of Birth: _____ Where Living: _____
Name: _____ M/F Date of Birth: _____ Where Living: _____
Name: _____M/F Date of Birth: _____ Where Living: _____

Primary Physician: _____ Phone: _____
Address: _____ Fax: _____
Date of last physical exam: _____ Email: _____
Type and Dosage of Child's Medications: _____

Referred by: _____ Relationship: _____
Address: _____ Phone: _____
Email: _____

Child's School: _____ Grade Placement: _____
School Address: _____ (city) _____, (Zip) _____ School Phone: _____

Name of Teacher(s):_____
Name of School Counselor: _____

Did child attend preschool? _____ At what ages?_____
Were any problems noted with behavior? _____
Were any problems noted with early learning skills? _____ At what age?_____ Please specify learning problems: _____
_____
_____
_____

What questions would you like this evaluation to address: _____
_____
_____
_____
Who first expressed a concern about your child's learning skills? _____ At what age? _____

Has your child been evaluated or tested before? If so, please list dates and name of evaluator. Please sign arelease of information for each evaluator and provide me with copies of any evaluations.

Evaluator	Dates	Reason for Evaluation
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child have any problems doing homework? _____ If yes, please describe in detail: _____
_____
_____
_____

Is your child receiving any special education services? _____ If yes, please identify services: _____
_____
_____
_____

Was child ever retained or recommended to be retained? _____ If so, at what age/grade? _____

Are there other areas where the learning problem(s) interfere with your child's functioning? (i.e. family, peer relationships, etc.):_____
_____
_____
_____

Does child have difficulty making friends? _____
Does child have difficulty keeping friends? _____
Does child prefer having younger friends? _____
Does child prefer having older friends? _____

What do you identify as your child's greatest strengths? _____
_____

_____
_____

Family Medical History

Family medical history (i.e. diabetes, seizures, neurological problems, cardiac problems, metabolic problems, attention deficit disorder, learning disorders, depression, anxiety, manic-depression, schizophrenia, motor ties, obsessive-compulsive disorder, suicide, alcoholism, substance abuse, etc.): _____
_____
_____
_____
_____

Is there a history of learning or attention problems in the family? _____ If yes, please describe in detail: ____
_____
_____
_____

Please list any major stresses that have occurred to any family member within the last five years: _____
_____
_____
_____

Please list any history of serious physical or mental illness of any family member: _____
_____
_____
_____

Birth History

Is your child adopted? _____ If yes, please give age when adopted: _____

If your child was adopted, please describe the prenatal care, early childhood care and development, and anything you can add about the early learning environment that your child experienced before adoption: _____
_____
_____
_____

Was this a planned pregnancy? _____ Length of this pregnancy: _____
Were any miscarriages suffered? _____ Number of miscarriages: _____

Any difficulties suffered during this pregnancy? _____ If yes, please describe in detail: _____
_____
_____

Were any medications given during pregnancy? _____ If yes, please describe in detail: _____
_____

Length of Labor: _____ Type of delivery: _____ (i.e. vaginal, cesarean, breech)

Any difficulties during delivery? _____ If yes, please describe in detail: _____
_____
_____

Baby's Condition at Birth

Cord around neck:	No	Yes	Injured during birth:	No	Yes	Breathing difficulty:	No	Yes
Required oxygen:	No	Yes	Turned blue:	No	Yes	Had an infection:	No	Yes
Placed in incubator:	No	Yes	Difficulty sucking:	No	Yes	Jaundiced:	No	Yes

Please list any other problems at birth: _____
_____
_____

Genetic or congenital conditions? Please specify: _____
_____
_____

Early Life Difficulties

Feeding difficulties: No Yes Age: _____
Unwillingness to try new foods: No Yes Age: _____
Extreme hunger: No Yes Age: _____
Constipation: No Yes Age: _____
Stomach aches: No Yes Age: _____
Very unpredictable length of sleep: No Yes Age: _____
Overactivity: No Yes Age: _____
Rocking in bed: No Yes Age: _____
Self-destructive behavior: No Yes Age: _____
Stiffness or rigidity: No Yes Age: _____
Crying often/easily: No Yes Age: _____
Bashful with new children: No Yes Age: _____
Extreme reaction to noise/sudden movement: No Yes Age: ____
Failure to be affectionate toward parents: No Yes Age: ____
Tendency to make odd sounds, grunts, snorts: No Yes Age: _____

Poor Appetite: No Yes Age: _____
Very unpredictable appetite: No Yes Age: _____
Colic: No Yes Age: _____
Headaches: No Yes Age: _____
Trouble falling asleep: No Yes Age: _____
Very heavy sleeping: No Yes Age: _____
Head banging: No Yes Age: _____
Temper tantrums: No Yes Age: _____
Difficulty being comforted/consoled: No Yes Age: _____
Looseness or floppiness: No Yes Age: _____
Shyness with strangers: No Yes Age: _____
Irritability: No Yes Age: _____
Difficulty keeping to a schedule: No Yes Age: _____
Unwillingness to go along w/change in daily routine No Yes Age: _____
Tendency to twitch or jerk arm(s) or head often: No Yes Age: _____

Early Development

Sat up without help: ____ Months ____Years
Walked alone (10-15 steps): ____ Months ____Years
Rode a tricycle: ____ Months _____Years
Spoke first words: ____ Months _____Years
Spoke clearly so strangers understood: __ Months __Years
Used a spoon: ____ Months _____Years
Fully bladder trained: ____ Months _____Years
Able to tie shoelaces: ____ Months _____Years

Crawled: _____ Months _____Years
Walked up stairs: _____ Months _____Years
Caught a ball: _____ Months _____Years
Put words together: _____ Months _____Years
Used fingers to feed self: _____ Months _____Years
Fully bowel trained: _____ Months _____Years
Able to dress self: _____ Months _____Years
Able to separate easily from mom (school/play): _____ Months _____Years

Child's Medical History

Head injury:	No	Yes	Age: _____
Loss of consciousness:	No	Yes	Age: _____
Motor tics or vocalizations:	No	Yes	Age: _____
Ear infections:	No	Yes	Age: _____
P.E. tubes:	No	Yes	Age: _____
Meningitis:	No	Yes	Age: _____
Seizures:	No	Yes	Age: _____
Injuries:	No	Yes	Age: _____
Bowel problems:	No	Yes	Age: _____
Chicken Pox:	No	Yes	Age: _____
Measles:	No	Yes	Age: _____
Asthma or allergies:	No	Yes	Age: _____
Food allergies:	No	Yes	Age: _____
Other allergies:	No	Yes	Age: _____
Hospitalizations:	No	Yes	Age: _____
Slow weight gain:	No	Yes	Age: _____
Heart problems:	No	Yes	Age: _____
Others:	No	Yes	Age: _____

Any serious or chronic illnesses: _____ If yes, please specify: _____
_____
_____

Any surgeries? _____ If yes, please specify: _____
_____
_____

Any hearing or vision problems? _____ If yes, please specify: _____
_____
_____

Date of last vision exam: _____
Date of last hearing exam: _____

Please note any other concerns/issues you would want me to be aware of as we start working together: _____
_____
_____
_____
_____
_____
_____
_____