Demographic Information

Today's Date: __/__/____

Child Name: ___________________________ Parent Name: ___________________________

Birth Date: __/__/____ Age: ______ Grade: _____ Gender: _____________________

Address: ____________________________________ Home Phone: ______________________

____________________________________ Cell Phone: ________________________

Email: ______________________________________

Which is your preferred method of contact? (please circle) Home Phone Cell Phone

What is a good time of day to reach you? ____

Reasons for Referral

Who referred you? ____

Briefly describe the reason you are here: ____
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____
____

How long has this reason been noticeable to you? ______________________________________

How old was your child when the symptoms first occurred? ______________________________

How often do you notice the problem? ____

What areas of your child's life are most affected and how (i.e. relationships, school, home)?
____
____
____

Diagnoses (Yes No) If yes, please explain: ____
____

What is the name of the doctor that made the diagnosis? ________________________________

Is your child currently taking any medications (including psychiatric/behavior medications)?

(Yes No) If yes, please write name(s) and dosage: ____________________________________

____

What is the child's family/household composition (i.e. lives with mother, father and brother)?

____

____

Educational History

What school district does your child attend? ____

What is your child's educational placement (i.e. mainstream, inclusion, self-contained)?

____

What is your child's classification (if any)? ____

Does your child receive services/accommodations at school? (Yes No)

If yes, describe the services/accommodations your child receives and how often they are received (i.e. speech, OT, PT). ____

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Medical History

Does your child have any current medical or health concerns (Yes No) If yes, please list:

____

____

Does your child have any chronic or recurrent medical or health concerns (i.e. diabetes, asthma)? (Yes No) If yes, please list: ____

____

Is your child currently taking any medications for his/her medical condition? (Yes No) If yes, please list: ____
____

Have any other family members shown similar difficulties or challenges? (Yes No) If yes, who?
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