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**Child Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REASONS FOR EVALUATION/THERAPY**

**Who referred your child?**                                                   

**Please describe the problems, questions or concerns for which you are seeking help at this time. Also, please indicate when these problems were first noticed.**

|  |  |
| --- | --- |
|  | **At what age were problems first noticed** |
|  |  |
|  |  |

**What do you think might be the reason for your child’s difficulties?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TEMPERAMENT/ CHILD’S PERSONALITY CHARACTER**

Please indicate whether your child has shown any of the following behaviors. Explain, if possible.

|  |  |
| --- | --- |
| ⬜ Excessive crying | ⬜ Interrupts frequently |
| ⬜ Talks about wanting to die | ⬜ Peer problems |
| ⬜ Social withdrawal | ⬜ Frequent temper tantrums |
| ⬜ Destructiveness | ⬜ Defiance of authority |
| ⬜ Ritualistic behaviors | ⬜ Delinquent behavior (e.g., lying, stealing) |
| ⬜ Anxiety, nervousness, excessive worries  ⬜ Odd thinking or speech | ⬜ Nightmares, night terrors, sleep walking, talking in sleep |
| ⬜ Poor attention | ⬜ Difficulty falling or staying asleep |
| ⬜ Fidgets / Can’t sit still | ⬜ Inappropriate sexualized behaviors |
|  |  |

Other Concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**History of mental health treatment** ⬜ Yes ⬜ No Inpatient treatment? ⬜ Yes ⬜ No

**If yes, where and when?**

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**What was the treatment outcome?**                                                                                                                                                                                                    \_

**SOCIAL HISTORY**

**Mother's name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_**

**Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital status\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Check which applies:** ⬜ Biological/birth ⬜ Adoptive ⬜ Step ⬜ Foster ⬜ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Father's name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_**

**Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital status\_\_\_\_\_\_\_\_\_\_\_**

**Check which applies:** ⬜ Biological/birth ⬜ Adoptive ⬜ Step ⬜ Foster ⬜ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If parents are separated or divorced, who has custody of this child?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How often does the other parent see this child? (check one)**

⬜ Weekly or more often ⬜ Once or twice a month ⬜ Few times a year ⬜ Never

**How long have the parents been separated?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**With whom is child currently living (list members of household and primary caregivers)?**

Name Age Relationship to patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DEVELOPMENTAL HISTORY**

**PREGNANCY HISTORY**

Note: This information relates to birth (biological) parent.

**Mother’s age at delivery?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Did you recevie prenatal care?**  No  Yes

**Mother's health during pregnancy** (check)  Good  Fair  Poor

**BIRTH HISTORY**

**Where was the child born? Name of Hospital and Location (City, State, Country)**

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**Length of pregnancy**                

**Labor was** (check one)  easy, no problems difficult: explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of delivery:**  Natural (vaginal)  C-section  Forceps  Vacuum  Induced / Augmented

**Baby's position:**  Head down (vertex)  Legs or bottom down (breech)

**Were there any problems during labor or delivery?** Yes No

If Yes, explain:

**Birth weight:**            **Length:**                 **Head circumference**                

**Duration of mother's hospital stay**                 **Duration of baby's hospital stay**      

**Were there any problems while the baby was in the hospital?**  Yes  No

If yes; the reason(s)

Have you ever been worried that your child's development was slower than it should be?  Yes  No

If yes, explain:                                        

Have you ever been worried that your child has lost skills that he/she used to have?  Yes  No

If yes, explain:                                        

**SKILLS ACQUISITIONS**

Please write the age at which your child did each of the following. If you cannot recall exactly, please indicate early, normal, late, or not achieved yet = NA.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **MOTOR** | Age | Early | Normal | Late | NA | Typical Age (months) |
| Rolled over front to back |  |  |  |  |  | 4-6 |
| Sat without support |  |  |  |  |  | 7-8 |
| Crawled on hands and knees |  |  |  |  |  | 7-8 |
| Walked with no help |  |  |  |  |  | 10-15 |
| Ran well |  |  |  |  |  | 21 |
| **USE OF HANDS** |  |  |  |  |  |  |
| Reached for object and grabbed it |  |  |  |  |  | 4-5 |
| Finger fed |  |  |  |  |  | 7-8 |
| Picked up small things (e.g.,Cheerios) between 2 fingers |  |  |  |  |  | 12 |
| Scribbled |  |  |  |  |  | 12-15 |
|  | Age | Early | Normal | Late | NA | Typical Age (months) |
| Used a spoon without spilling |  |  |  |  |  | 15-18 |
| Tied shoelaces |  |  |  |  |  | 60-72 |
| Wrote his or her name |  |  |  |  |  | 60 |
| **LANGUAGE** |  |  |  |  |  |  |
| Smiled Responsively |  |  |  |  |  | 1-2 |
| Babbled |  |  |  |  |  | 6 |
| Said “da-da” or “ma-ma” |  |  |  |  |  | 8-9 |
| Understood “No” |  |  |  |  |  | 8-10 |
| First word other than “mama” or “dada” |  |  |  |  |  | 11-12 |
| Pointed to named picture (“Show me the dog.”) |  |  |  |  |  | 18 |
| Pointed to 1 - 4 body parts |  |  |  |  |  | 18-20 |
| 2 word phrases (“Let’s go”) |  |  |  |  |  | 21 |
| 3 word sentences |  |  |  |  |  | 36 |
| Said first and last name |  |  |  |  |  | 36 |
| **SOCIAL/GENERAL SKILLS** |  |  |  |  |  |  |
| Laughed |  |  |  |  |  | 2-4 |
| Smiled and made faces at mirror |  |  |  |  |  | 4 |
| Played peek-a-boo |  |  |  |  |  | 7-9 |
| Imitated tricks such as waving |  |  |  |  |  | 9 |
| Undress self |  |  |  |  |  | 36 |
| Dress self |  |  |  |  |  | 48 |
| Pointed to show items of interest |  |  |  |  |  | 9-14 |
| Would bring items to show you |  |  |  |  |  | 14 |
| Toilet Trained: Day |  |  |  |  |  | 24-36 |
| Toilet Trained: Night |  |  |  |  |  | 36-48 |

**HEALTH HISTORY**

**Current Weight**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Height**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hearing Vision**

Ear infections ⬜ Vision problems

Ear tubes ⬜ Wears glasses or contacts

Hearing problems ⬜ Eyes turning in or out

**List any PAST accidents chronic or severe medical problems your child required frequent care by a doctor or follow-up by a specialist:**

**Reason Date Age Doctor / Specialist**

                                                                              

                                                                              

                                                                              

**List all CURRENT medical problems and medications your child is taking at this time:**

**Medical Problem Dosage Name of medication Doctor/Specialist**

**Has child ever had a bad reaction to a medicine?**  Yes  No

Explain if Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT SKILLS

Please check the column that best describes your child compared to other children of the same age:(for school age / preschool children):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Skill or Ability** | Above Average | Average | Below Average | Not Sure |
| Throwing/catching |  |  |  |  |
| Running, jumping |  |  |  |  |
| Imaginary Play |  |  |  |  |
| Balance |  |  |  |  |
| Understanding spoken instructions |  |  |  |  |
| Expressing self verbally |  |  |  |  |
| Speaking clearly |  |  |  |  |
| Reading |  |  |  |  |
| Handwriting |  |  |  |  |
| Spelling |  |  |  |  |
| Math |  |  |  |  |
| Completing homework |  |  |  |  |
| Building things |  |  |  |  |
| Self help, Dressing self |  |  |  |  |
| Tying shoes, buttoning, zipping |  |  |  |  |
| Ability to make friends |  |  |  |  |
| Ability to keep friends |  |  |  |  |

**SCHOOL HISTORY**

Current School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main Teacher:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resource Room Teacher:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What special services he/she is receiving**?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GPA:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has child ever been retained a grade or held back?** ⬜ No ⬜ Yes (explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has child ever been suspended**? ⬜ No ⬜ Yes (explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of Department of Social Services (DSS) involvement**: ⬜ No ⬜ Yes

If Yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Suspect your child’s drug or alcohol use? ⬜ No ⬜ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any legal problems: ⬜ No ⬜ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check any problems child has had in school in the past compared to other typical students:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Grade** | Unable to pay attention, stay on task, or complete assignments | Problems with learning, low or failing grades | Problems with behavior at school | Special Education or Interventions attempted by school |
| Preschool |  |  |  |  |
| Kindergarten |  |  |  |  |
| First |  |  |  |  |
| Second |  |  |  |  |
| Third |  |  |  |  |
| Fourth |  |  |  |  |
| Fifth |  |  |  |  |
| Sixth |  |  |  |  |
| Seventh-Ninth |  |  |  |  |
| Ninth-Twelfth |  |  |  |  |

**FAMILY MENTAL HEALTH/DEVELOPMEENTAL HISTORY**

Does anyone in the family have any of the following? Check all that apply, past or present.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Condition | Mother | Father | Sibling | Mother's Family | Father's Family |
| Learning disorder |  |  |  |  |  |
| Attention problems; hyperactivity |  |  |  |  |  |
| Depression/bipolar |  |  |  |  |  |
| Suicide attempts |  |  |  |  |  |
| Anxiety disorder/panic attacks |  |  |  |  |  |
| Psychosis or schizophrenia |  |  |  |  |  |
| Obsessive-compulsive disorder |  |  |  |  |  |
| Alcohol or drug abuse |  |  |  |  |  |
| Tics or Tourette syndrome |  |  |  |  |  |
| Developmental Delays |  |  |  |  |  |
| Seizures |  |  |  |  |  |
| Autism |  |  |  |  |  |
| Birth defects or familial disorder |  |  |  |  |  |
| Cerebral palsy |  |  |  |  |  |
| Speech or Language Problem |  |  |  |  |  |

PARENTS’ THERAPY GOALS

**What are you hoping to have happen or gain from evaluation/therapy?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_