PEDIATRIC SCHOOL PSYCHOLOGY:
EVALUATION AND CONSULTATION SERVICES, LLC
3612 Landmark Drive, Suite A, Columbia, South Carolina 29204

CHILD & FAMILY INFORMATION FORM

The information you provide in this form will help us learn about your child's developmental & family history as well as your viewpoints on his/her current strengths & weaknesses, and will help us prepare for the consultation and/or evaluation, and complete a comprehensive report that covers all of your child's needs. Please be complete as possible.

Today's Date: _____ **Address:** _____

Name of Child: _____ _____

Date of Birth: _____ **Home Phone:** _____

Name of Parent (s): _____ **Cell Phone:** _____

Child's Grade: _____ **Work Phone:** _____

Child's School: _____ **E-Mail:** _____

Referred By: _____ **Contact Preference (*phone or email*):** _____

Parent's Concerns:

What are your main concerns and goals for your child's evaluation/consultation?

When were the concerns for your child first noticed?

What have you done to-date to help support your child?

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DATE *CHILD & FAMILY PACKET* RECEIVED: _____ **DATE *SCHOOL FORMS* RECEIVED:** _____

CONTACT DATES:_____

Child's Strengths: (list your child's assets related to his/her personality, character, behavior, socialization, learning, etc.)

Child's Weaknesses: (list your child's difficulties with his/her behavior, self-esteem, socialization, learning, etc.)

Child's Diagnoses: (list any **current** diagnoses such as ADHD, anxiety, autism, learning disability, ADHD, etc.)

Pregnancy & Birth History:

Pregnancy: (please list general health of mother as well as any problems and/or complications)

Child's Birth Weight/Length of Pregnancy:

Delivery Type (head first, feet first, breech, Cesarean) **and Complications During Delivery:** (list any problems during the delivery)

Newborn Issues: (please list any problems or complications such as treatment in the NICU, jaundice, feeding issues, failure to thrive, etc.)

Child's Medical History:

Who is your child's pediatrician?

When was your child's last's well-check with his/her pediatrician? Was it within normal limits?

Has your child been hospitalized for any reason? (if yes, please explain)

Child's Medical History: (continued)

Does your child have any allergies, health issues, and/or medical conditions? (if yes, please explain)

Is your child followed by other pediatric specialists (such as pediatric neurologist, pediatric endocrinologist, child psychiatrist, etc.)**, and what were their conclusions and recommendations?**

Child's Medication History:

Has your child ever taken on-going medications? (if yes, please list all previous medications, positive and/or negative side effects, length medicine was taken, why it was stopped, etc.)

Is your child currently taking any medications? (if yes, please explain)

Child's Vision and Hearing:

Does your child have vision problems? When / where was the last vision screening (e.g., pediatrician's office, school, optometrist) **and what were the results?**

Does your child have hearing problems? When/ where was the last hearing screening (e.g., pediatrician's office, school, audiologist) **and what were the results?**

Child's Sleeping Patterns and Eating Habits:

Please comment on your child's sleeping patterns.

Please comment on your child's eating habits.

Please include any additional health information on your child.

Family Information:

Mother's Name/Age: _____ **Father's Name/Age:**_____
Education: _____ **Education:** _____
Occupation: _____ **Occupation:** _____
Parents are? (married, divorced, separated, etc.) _____
Primary Language in the Home: _____

Household: (who does the child live with? Biological parents, stepparents, siblings, grandparents, etc. Please give names and ages.)

Family Relationships: (how does child get along with mother, father, and siblings?)

Significant Life Stressors: (move to a new home, move to a new school, divorce, marital stress, death in family, etc.)

Family History: *(note the family member that has a history and briefly describe if necessary)*					
	Mother	*Father*	*Brother/Sister*	*Other Relative (please specify)*	*Other Relative (please specify)*
Gifted/Honors Student					
Repeated Grade					
Received Special Education					
Learning Disabilities					
Reading Problem/Dyslexia					
Math Problem/Dyscalculia					
Writing Problem/Dysgraphia					
Other Learning Problems					
Vision Impairment					
Hearing Impairment					
Communication/Language Problems					
Speech/Articulation Problems					
Receptive Language Problems					
Expressive Language Problems					
Other Communication Issues					
Attention Problems/ADHD					
Behavior Problems					
Autism Spectrum Disorder/Asperger's					
Developmental Delay/ Mental Retardation/Intellectual Disability					
Cerebral Palsy					
Neurological Condition					
Depression					
Anxiety					
Bipolar					
Schizophrenia					
Alcohol/Substance Abuse					
Other Mental Health Problem (explain)					

***Please explain any other family health/mental health issues that are diagnosed or suspected.**

Developmental History: Did your child have any delays in his/her development? Which areas?

Developmental Milestones: *(check when child achieved each milestone)*													
	2m	*4m*	*6m*	*9m*	*12m*	*15m*	*18m*	*2y*	*3y*	*4y*	*5y*	*6y*	*Not Yet*
Sat Unsupported													
Crawled													
Walked Alone (10-15 steps)													
Rode a Tricycle													
Caught a big ball													
Spoke first words													
Put words together													
Spoke 2-3 word sentences													
Spoke Clearly													
Used a spoon													
Started Potty-Training													
Finished Potty-Training													
Dressed self													
Tied shoe laces													
Separated easily from caregiver (for school & play)													

***Other concerns/comments about your child's attainment of developmental milestones:**

Communication and Language Skills:

How is your child currently doing? (saying words clearly, expressing self, understanding words, explaining, etc.)

Has your child had speech-language therapy? (if so, when, how long, and what were the goals and progress?)

Motor Functioning and Sensory Regulation:

How well does your child use gross motor skills? (running, playing in sports, etc.)

How well does your child use fine motor skills? (cutting with scissors, handwriting, completing artwork, etc.)

Does your child have any sensory issues? (unusual reactions to touch, sound, etc.)

Has your child had physical therapy (PT), occupational therapy (OT), and/or sensory integration therapy? (if so, when, how long, and what were the goals and progress?)

CURRENT Independent Functioning: (independently-*with little supervision*- completing self-care and domestic activities as well as knowledge of community resources/health safety issues, and general daily living skills)

Child's School History: (list daycares/schools attended and any significant information for each)

Before age 3:

Preschool:

Kindergarten:

Early Elementary (1st-3rd):

Late Elementary (4th-5th):

Grade Retention: (has your child repeated a grade? If so, which one?)

Special Supports/Special Education: (has your child received extra support prior to school or at school? If so, attach current Individual Education Plan-IEP, Section 504 Plan, Individual Family Service Plan-IFSP, and/or any other plan created)

Academic Performance:

Past:

Current:

Child's Relationship with Teacher (s):

Homework Issues:

Child's Behavioral, Emotional, and Social Functioning: (briefly note any problem areas or important information)

Behavioral Functioning:
PAST: (please comment on your child's behaviors as a toddler, while in preschool, in elementary school, etc.)

CURRENT: (please note how your child is doing in each area now)
Attention:

Activity Level/Impulsivity:

Compliance:

Aggression/Anger/Tantrums:

Ability to Adjust to Change in Routine:

Unusual Behaviors/Atypicality:

Discipline Strategies Used at Home:

Emotional Functioning:
PAST: (please comment on your child's emotionality as a toddler, while in preschool, in elementary school, etc.)

CURRENT: (please note how your child is doing in each area now)
Self-Esteem:

Depression/Sadness/Mood Swings:

Stress/Anxiety/Worry/Fears:

Obsessions:

Other:

Social Functioning:

PAST: (please comment on your child's social behaviors as a toddler, while in preschool, in elementary school, etc.)

CURRENT: (please note how your child is doing in each area now)
Play:

Imaginary/Pretend Play:

Friendships:

Social-Communication: (to/fro conversational skills, knowledge of personal space issues, awareness of nonverbal body language and social cues, etc.)

Extracurricular Activities:

Child's Developmental, Behavioral, Emotional, and/or Social Supports: (please list your child's participation in early intervention services, ABA therapy, counseling, coaching, social skills groups, etc.)

Child's Prior Evaluations for Emotional, Behavioral, or Learning Problems: (please list all here and attach copy of each of the reports)

Is there anything else that you would like me to know about your child as we plan for the evaluation?