



**PEDIATRIC SCHOOL PSYCHOLOGY**  
**EVALUATION AND CONSULTATION SERVICES**

3612 LANDMARK DRIVE, SUITE A, COLUMBIA, SC 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 ( <i>phone or email</i> ):	_____

**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?

.... OFFICE USE ONLY ....

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.)

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

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

**\*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 (1<sup>st</sup>-3<sup>rd</sup>):**

**Late Elementary (4<sup>th</sup>-5<sup>th</sup>):**

**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?**