PSYCHOLOGICAL ASSESSMENT BACKGROUND INFORMATION
CHILD

	Today's Date
Who referred you?	
Client Information	
Child's Last Name	Child's First Name
Child's Date of Birth	Who does child live with?
Family Information	
Parent One's Last Name	Parent One's First Name
Address	
Home phone number	Cell phone number
Occupation	Highest level of education
Parent Two's Last Name	Parent Two's First Name
Address	
Home phone number	Cell phone number
Occupation	Highest level of education

List all people who live in the home.		
Name	Age	Relationship

Are there any brothers or sisters living outside of the home? Please list:		
Name	Age	Relationship

Primary language spoken in the home:	Secondary language spoken in the home:

Family History

Parent One's occupation	Parent Two's occupation
Parent One's highest level of education	Parent Two's highest level of education
Primary language spoken in the home	Secondary language spoken in the home

Please check any illness or condition that any member of your immediate family (birth parents, siblings, half siblings, aunts or uncles, grandparents) has had. Indicate which family member and describe.

Illness or Condition		Family Member
Depression	Yes No	
Anxiety	Yes No	
Obsessive-Compulsive Disorder	Yes No	

Suicidality	Yes No	
Learning disabilities	Yes No	
Hyperactivity	Yes No	
Attention Deficit/Hyperactivity Disorder (ADHD or ADD)	Yes No	
Repeated a grade	Yes No	
Needed special education or tutoring	Yes No	
Any psychiatric or psychological problems for which treatment was received	Yes No	

Medical and Developmental History

Please answer to the best of your knowledge.

During pregnancy, was mother on medication?	Yes No	If yes, what medication and for what reason?
During pregnancy, did mother smoke?	Yes No	If yes, how many cigarettes a day?
During pregnancy, did mother drink alcoholic beverages?	Yes No	If yes, How many drinks a day? What did she drink?
During pregnancy, did mother use drugs?	Yes No	If yes, how many drinks a day?
Were forceps used during delivery?	Yes No	
Was a Caesarian section performed?	Yes No	If yes, for what reason? Was it an emergency C-section?

Was the child born prematurely?	Yes No	If yes, how many weeks prematurely? What was the reason for premature delivery?
What was the child's weight at birth?		
Describe any birth defects or complications during delivery.		
Describe and feeding or sleeping problems during infancy.		
Describe any special problems in growth or development during the first few years.		

Please indicate if the child met the following developmental milestones on time. If not, please indicate if the child met them early or late and to what degree.		
Showed response to mother	Early On time Delayed Unsure	If early, how early? If delayed, how delayed?
Rolled over	Early On time Delayed Unsure	If early, how early? If delayed, how delayed?
Sat alone	Early On time Delayed Unsure	If early, how early? If delayed, how delayed?
Crawled	Early On time Delayed Unsure	If early, how early? If delayed, how delayed?
Fed self	Early On time Delayed Unsure	If early, how early? If delayed, how delayed?

Rode tricycle	Early On time Delayed Unsure	If early, how early? If delayed, how delayed?
Put several words together	Early On time Delayed Unsure	If early, how early? If delayed, how delayed?
Dressed self	Early On time Delayed Unsure	If early, how early? If delayed, how delayed?
Became toilet trained	Early On time Delayed Unsure	If early, how early? If delayed, how delayed?
Stayed dry at night	Early On time Delayed Unsure	If early, how early? If delayed, how delayed?
Spoke first word	Early On time Delayed Unsure	If early, how early? If delayed, how delayed?
Walked	Early On time Delayed Unsure	If early, how early? If delayed, how delayed?

Please circle if the child has had any of the following medical conditions:

Measles	German Measles	Mumps	Chicken Pox
Diphtheria	Whooping Cough	Scarlet Fever	Meningitis
Encephalitis	High Fever	Convulsions	Head Injury
Allergies	Broken Bones	Hospitalizations	Fainting Spells
Paralysis	Dizziness	Headaches	Memory Problems
Epilepsy	Tuberculosis	Visual Problems	Rheumatic Fever
Hearing Problems	Gonorrhea	Syphilis	Jaundice/Hepatitis
Diabetes	Cancer	High Blood Pressure	Heart Disease
Asthma	Asthma	Suicidality	Difficulty Concentrating

Stomach Problems	Obesity	Other (specify):
Please provide ages for any of the conditions circled above:		
Is your child currently taking any medication? Yes No		
If yes, please list current medication names, dosages, and reason for taking:		
Please list previous medications, when taken, for how long, and in what combinations (including past trials of medications for attention, depression, anxiety, etc.)		

EDUCATIONAL HISTORY

Please list all schools, starting with the most recent.

Name of School	Grades Attended	City/State

Elementary School
How did your child perform academically? What was harder or easier for your child? Did your child have any behavior problems?
Middle School/Junior High School
How did your child perform academically? What was harder or easier for your child? Did your child have any behavior problems?
High School
How did your child perform academically? What subjects were easier or harder for your child in high school?

Did your child have any behavior problems?
TREATMENT HISTORY
Is this the first time your child has undergone educational, intellectual, developmental, behavioral, or emotional testing?
If this is not your child's first evaluation, describe the reasons for testing, the dates of testing, and the findings, if known. Who performed it?
Has your child ever received formal or informal accommodations at school for learning, attention, executive functioning problems or other deficits? These might include extended time, permission to complete assignments in a resource room, etc. If so, please describe:

List all previous treatment, if any, your child has received for the current problem (including tutoring, speech and language therapy, occupational therapy, psychotherapy, etc.)		
Treated by	Type (e.g. occupational therapy)	Dates

Has your child ever been held back a grade?

Yes

No

If yes, which grade?

OTHER INFORMATION

Why are you seeking an evaluation now?

When was the problem first noticed?

What are your child's assets and strengths?

Please list any unusual, traumatic, or possibly stressful events in your child's life that you think may have had an impact on development and current functioning. Include the incident, age at the time, and comments:

Is there any other information that you think would be helpful in any way when working with your child?