



PSYCHOLOGICAL ASSESSMENT BACKGROUND INFORMATION  
CHILD

|                           |                            |
|---------------------------|----------------------------|
| Today's Date              |                            |
| Who referred you?         |                            |
| <b>Client Information</b> |                            |
| Child's Last Name         | Child's First Name         |
| Child's Date of Birth     | Who does child live with?  |
| <b>Family Information</b> |                            |
| 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 name                       | Parent Two's name                       |
| 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                    | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |               |
| Anxiety                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |               |
| Obsessive-Compulsive Disorder | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |               |

|  |   |  |
|--|---|--|
| Suicidality  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |  |
| Learning disabilities  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |  |
| Hyperactivity  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |  |
| Attention Deficit/Hyperactivity Disorder (ADHD or ADD)                     | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |  |
| Repeated a grade   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |  |
| Needed special education or tutoring                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |  |
| Any psychiatric or psychological problems for which treatment was received | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |  |

### Medical and Developmental History

*Please answer to the best of your knowledge.*

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

|  |   |  |
|--|---|--|
| Was the child born prematurely?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No   | If yes, how many weeks prematurely?<br><br>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  | <input type="checkbox"/> Early<br><input type="checkbox"/> On time<br><input type="checkbox"/> Delayed<br><input type="checkbox"/> Unsure | If early, how early?<br><br>If delayed, how delayed?                                   |
| Rolled over  | <input type="checkbox"/> Early<br><input type="checkbox"/> On time<br><input type="checkbox"/> Delayed<br><input type="checkbox"/> Unsure | If early, how early?<br><br>If delayed, how delayed?                                   |
| Sat alone  | <input type="checkbox"/> Early<br><input type="checkbox"/> On time<br><input type="checkbox"/> Delayed<br><input type="checkbox"/> Unsure | If early, how early?<br><br>If delayed, how delayed?                                   |
| Crawled  | <input type="checkbox"/> Early<br><input type="checkbox"/> On time<br><input type="checkbox"/> Delayed<br><input type="checkbox"/> Unsure | If early, how early?<br><br>If delayed, how delayed?                                   |
| Fed self   | <input type="checkbox"/> Early<br><input type="checkbox"/> On time<br><input type="checkbox"/> Delayed<br><input type="checkbox"/> Unsure | If early, how early?<br><br>If delayed, how delayed?                                   |

|                            |   |  |
|----------------------------|---|--|
| Rode tricycle              | <input type="checkbox"/> Early<br><input type="checkbox"/> On time<br><input type="checkbox"/> Delayed<br><input type="checkbox"/> Unsure | If early, how early?<br><br>If delayed, how delayed? |
| Put several words together | <input type="checkbox"/> Early<br><input type="checkbox"/> On time<br><input type="checkbox"/> Delayed<br><input type="checkbox"/> Unsure | If early, how early?<br><br>If delayed, how delayed? |
| Dressed self               | <input type="checkbox"/> Early<br><input type="checkbox"/> On time<br><input type="checkbox"/> Delayed<br><input type="checkbox"/> Unsure | If early, how early?<br><br>If delayed, how delayed? |
| Became toilet trained      | <input type="checkbox"/> Early<br><input type="checkbox"/> On time<br><input type="checkbox"/> Delayed<br><input type="checkbox"/> Unsure | If early, how early?<br><br>If delayed, how delayed? |
| Stayed dry at night        | <input type="checkbox"/> Early<br><input type="checkbox"/> On time<br><input type="checkbox"/> Delayed<br><input type="checkbox"/> Unsure | If early, how early?<br><br>If delayed, how delayed? |
| Spoke first word           | <input type="checkbox"/> Early<br><input type="checkbox"/> On time<br><input type="checkbox"/> Delayed<br><input type="checkbox"/> Unsure | If early, how early?<br><br>If delayed, how delayed? |
| Walked                     | <input type="checkbox"/> Early<br><input type="checkbox"/> On time<br><input type="checkbox"/> Delayed<br><input type="checkbox"/> Unsure | If early, how early?<br><br>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):    |                          |



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?