



SUZANNE NANGLE, PH.D.
Licensed Clinical Psychologist
Certified School Psychologist
Center for Child Assessment & Therapy, Media
221 North Olive Street, First Floor
Media, PA 19063
O: (610) 565-3886
C: (610) 283-8407
snangle@ccatmedia.com

Date _____

(Please feel free to continue entries on back of pages, if needed.)

Child's full name _____

Child's Address _____

Birthdate _____ Age _____ Sex _____ Ethnic Group _____

Form filled out by _____

Phone _____ Relationship to Child _____

A. What concerns you about your child?

How long have these problems existed?

Why do you think your child is having problems now?

Have you previously sought help? No _____ Yes _____ If yes, please describe why, where and when:

What would you like to learn from this evaluation?

A. Persons with legal custody of child (state if adoptive, step, or foster parent):

1. Name _____ Relationship to child _____

Address (if different from child's) _____

Home Phone _____ Birth Date _____ Highest Education Completed _____

Cell Phone _____ E-mail Address _____

Usual Type of Work _____ Place of Work _____

Work days/hours _____ Work Phone _____

Presently married? Yes _____ No _____ Any previous marriages? Yes _____ No _____

2. Name _____ Relationship to child _____

Address (if different from child's) _____

Home Phone _____ Birth Date _____ Highest Education Completed _____

Cell Phone _____ E-mail Address _____

Usual Type of Work _____ Place of Work _____

Work days/hours _____ Work Phone _____

Presently married? Yes _____ No _____ Any previous marriages? Yes _____ No _____

D. Adults and children living in child's home, if not listed above:

Name	Age	Sex	Relationship to child (state if step, adoptive, foster, unrelated)

E. Child's brothers and sisters not living in child's home:

Name (state if half, step, or adoptive) Age Sex Living Where? How often does s/he see child?

F. Child care arrangements: Does anyone beside parents take care of the child on a regular basis? No Yes

If yes, please answer all that apply:

Babysitter in child's home. Hrs./wk: _____ Babysitter outside child's home Hrs/wk _____

G. Child's Medical History

No Yes Please Describe

- | | | | |
|---|-------|-------|-------|
| 1. Medical problems during mother's pregnancy with this child | _____ | _____ | _____ |
| 2. Medications during pregnancy? | _____ | _____ | _____ |
| 3. Did mother smoke or use alcohol or drugs during pregnancy? | _____ | _____ | _____ |
| 4. Any stress during pregnancy? (such as marital, job, money, living conditions, alcohol/drug problems?) | _____ | _____ | _____ |
| 5. Problems during labor or delivery (such as prolonged labor, bleeding, breech birth) | _____ | _____ | _____ |
| 6. Was the child born premature? | _____ | _____ | _____ |
| 7. Birthweight: _____ lbs. _____ oz. | | | |
| 8. Problems in newborn period or infancy? (such as being born blue, birth defects, jaundice, seizures, infections, injuries, feeding or sleep problems) | _____ | _____ | _____ |
| 9. Was child difficult to care for as a baby | _____ | _____ | _____ |
| 10. Does the child have allergies? (e.g., dust, pollen, pets) | _____ | _____ | _____ |

11. Please describe below all severe illnesses, accidents, operations, handicaps and repeated medical problems (such as ear infections, headaches, broken limbs, tonsillectomy), specifying age, treatment, etc.

12. Are you concerned about any aspect of the child's health? _____

13a. Does child take any medication now for any purpose _____ If yes, please describe below

Name of Medication	Dose	Purpose	Effect (include side effects)	Doctor
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

b. Was any medication ever prescribed for behavior problems? No _____ Yes _____ Please describe:

Name of Medication	Dose	Purpose	Effect (include side effects)	Doctor
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

c. Is the child allergic to any medication? No _____ Yes _____ If yes, please describe:

14. Child's pediatrician _____ Phone# _____

Pediatrician's address _____

Date of last complete checkup _____ Outcome _____

H. Child's Developmental History

	No	Yes	Please describe
1. Have you noticed any problems in development?	_____	_____	_____
2. Were any of the following difficult or slow to develop?			
a. walking alone	_____	_____	_____
b. speaking	_____	_____	_____
c. bowel training	_____	_____	_____
d. bladder training	_____	_____	_____
e. staying dry at night	_____	_____	_____
f. riding bike without training wheels	_____	_____	_____
g. tying shoes	_____	_____	_____
h. gross motor coordination	_____	_____	_____
i. fine motor coordination	_____	_____	_____

3. Have there been problems in the following areas?

- a. discipline _____
- b. temper or fighting _____
- c. moods _____
- d. relationships with others _____
- e. other behaviors (please specify) _____

I. Child's Temperament

	No	Yes	Please Describe
1. Is your child overactive?	_____	_____	_____
2. Does your child have trouble paying attention?	_____	_____	_____
3. Does your child have trouble staying with one activity jumping from one thing to another or failing to finish?	_____	_____	_____
4. Does your child fluctuate from happy to sad quickly with little apparent cause?	_____	_____	_____
5. Does your child get frustrated easily?	_____	_____	_____
6. Is your child unusually irritable?	_____	_____	_____
7. Does your child get upset by abrupt changes?	_____	_____	_____
8. Are your child's emotional responses unpredictable?	_____	_____	_____
9. Does it take your child a long time to warm up to new situations or people?	_____	_____	_____
10. Does your child react strongly to physical pain?	_____	_____	_____
11. Does your child react strongly to other things?	_____	_____	_____
12. Other concerns about your child's temperament?	_____	_____	_____

J. Family History: Has any relative of the child had the following? If so, specify relationship to child.

	No	Yes	Relationship to child	Please Describe
1. <i>Neurological</i> disease, such as seizures, fits, weaknesses, etc.	_____	_____	_____	_____
2. <i>Medical</i> disease, such as diabetes, thyroid disease, heart disease, etc.	_____	_____	_____	_____
3. <i>Mental</i> illness (schizophrenia, manic depressive episodes, etc.)	_____	_____	_____	_____
4. <i>Physical or sensory</i> disabilities (motor, vision, sight, etc.)	_____	_____	_____	_____
5. Mental retardation	_____	_____	_____	_____
6. Learning problems	_____	_____	_____	_____
7. Behavior problems	_____	_____	_____	_____
8. Excessive use of alcohol	_____	_____	_____	_____

- 9. Excessive use of drugs _____
- 10. Trouble with the law _____
- 11. Trouble holding a job _____
- 12. Suicidal behavior _____
- 13. Other (please specify) _____

K. Current Living Situation

- | | Yes | No | Please Describe |
|--|------------|-----------|------------------------|
| 1. Is your present marital situation satisfying to you? | _____ | _____ | _____ |
| 2. Is your present work situation satisfying to you? | _____ | _____ | _____ |
| 3. Are your present living circumstances satisfying to you? | _____ | _____ | _____ |
| 4. Has anyone in your family seen a psychologist, Psychiatrist or other mental health worker? If yes, why? | _____ | _____ | _____ |
| 5. Have there been recent major changes or stresses in your living situation or family? | _____ | _____ | _____ |

L. Child's School History

1. Did child attend preschool? Yes _____ No _____ Where? _____ How long? _____
 Any problems during that time? Yes _____ No _____ Please describe:

2. Has your child had learning problems? No _____ Yes _____ If yes, please describe below.

3. Has your child had social problems in school? No _____ Yes _____ If yes, please describe below.

4. Has the child ever had a psychoeducational evaluation? No _____ Yes _____ When? _____
 By whom? _____
 What were the findings?

5. Is your child receiving special help at school? No _____ Yes _____ If yes, please describe below.

6. Any other school concerns? No _____ Yes _____ If yes, please describe below

M. Summary

1. Please describe your child's strengths.

2. Please feel free to write down anything else you think we should know.

Thank you very much.

If we have reason to suspect, on the basis of our professional judgment, that a child is or has been abused, we are required according to the Pennsylvania Child Protective Services Law to report our suspicions to the authority or government agency vested to conduct child abuse investigations. We are required to make such reports even if we do not see the child in our professional capacity. We are mandated to report suspected child abuse if anyone aged 14 or older tells us that he or she committed child abuse, even if the victim is no longer in danger. We are also mandated to report suspected child abuse if anyone tells us that he or she knows of any child who is currently being abused.