STACI HEINDEL, PH.D., LLC
CENTER FOR CHILD ASSESSMENT AND THERAPY
OFFICE LOCATIONS:
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Date _____ (**Please feel free to continue entries on back of pages, if needed**.)

A. Child's full name _____

Child's Address _____

Birthdate_____ Age _____ Sex _____ Ethnic Group _____ Grade _____

A. **Form filled out by** _____

Phone _____ Relationship to Child _____

B. What concerns you about your child?

_____

_____

_____

How long have these problems existed?

_____

Why do you think your child is having problems?

_____

_____

_____

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

_____

_____

_____

What would you like to learn from this evaluation?

_____

_____

_____

_____

C. 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 _____

If divorced, who has <u>legal</u> custody of the child? _____

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)

How does child get along with his/her sibling(s)?_____

_____

_____

E. Child's brothers and sisters <u>not</u> 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 challenging to care for as a baby?	____	____	_____
10. Does the child have allergies? (e.g., dust, pollen, pets)	____	____	_____
11. Does the child have eating problems? (too much/too little)	____	____	_____

12. 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.

_____

_____

_____

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

14a. 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

_____

_____

_____

4 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. first words	____	____	_____
c. combining words into phrases	____	____	_____
d. bowel training	____	____	_____
e. bladder training	____	____	_____
f. staying dry at night	____	____	_____
g. riding bike without training wheels	____	____	_____
h. tying shoes	____	____	_____
i. gross motor coordination	____	____	_____
j. 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. eating	____	____	_____
f. bedtime, sleeping	____	____	_____
g. 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. *Neurological* disease, such as seizures, fits, weaknesses, etc.	____	____	_____	_____
2. *Medical* disease, such as diabetes, thyroid disease, heart disease, etc.	____	____	_____	_____
3. *Mental* illness (schizophrenia, manic depressive episodes, etc.)	____	____	_____	_____
4. *Physical or sensory* 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. Has anyone in your family seen a psychologist, psychiatrist or other mental health worker? If yes, why?	____	____	_____
2. Have there been recent major changes or stresses in your living situation or family?	____	____	_____

L. Child's School History

1. Did your child ever receive Early Intervention services (infant/toddler or preschool)? Yes_____ No _____

If yes, what kind and where? _____

_____

How often (frequency and time/session? _____ For how long (duration)? _____

2.. Did child attend preschool? Yes ____ No ____ Where? _____ How long? _____

Any problems during that time? Yes ____ No ____ Please describe:

_____

_____

3. Has your child had learning problems? No____ Yes ____ If yes, please describe below.

_____

_____

4. Please list all schools your child has attended thus far since preschool.

Elementary School(s) _____

_____

_____

Intermediate/Middle School(s) _____

_____

_____

High School(s)_____

_____

_____

College(s) _____

_____

3. Has your child ever repeated a grade? No ____ Yes ____ Grade _____ If yes, why, and what was the outcome?

_____

_____

3. Has your child had social or behavioral problems in school? No ____ Yes ____ If yes, please describe.

_____

_____

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 right now? No____ Yes ____ If yes, please describe below.

_____

_____

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

_____

_____

M. Other Information

1. In what group and leisure activities does your child participate?

_____

_____

_____

2. Please describe your child's strengths.

_____

_____

_____

3. What do you see as your child's weaknesses?

_____

_____

_____

4. Please feel free to write down anything else you think I should know.

_____

_____

_____

_____

Thank you very much!