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Child Psychologial Evaluation Questionnaire

Patient's Name:_____ Today's Date: _____

Gender: M F Date of Birth: _____

Name of Person Completing Questionnaire: _____

Relationship to Patient: _____

Patient's Address: _____

Patient's Email:_____

School:_____ Grade/Year: _____

Parent 1 Name:_____ Age:_____

Best phone number to be reached: _____

Email: _____

Occupation:_____Education Level: _____

Parent 2 Name:_____ Age: _____

Best phone number to be reached: _____

Occupation:_____Education Level: _____

Best phone number to be reached: _____

Email: _____

Marital Status: Married (how long? _____)

Divorced (date of separation? _____)

Single Parent

Siblings: Name Age Grade and School or Career

Current Living Arrangements (with whom, visitation arrangements, type, e.g. house, apartment):

_____

_____

Referral Source: _____

If possible/relevant, please provide copies of any school records (IEPs, report cards) and/or previous assessment reports.

Please describe your child's strengths:

Please describe the challenges your child faces:

At the present time, what are your main concerns?

What would you like to see happen as a result of this treatment/evaluation?

Developmental History

Prenatal:

Give the age of each parent at the time of child's birth: Mother _____ Father _____

How many pregnancies have there been prior to the child's birth? _____

Has child's mother had any miscarriages or premature deliveries? _____

Was pregnancy planned or unplanned? _____

Did mother have any difficulty adjusting to pregnancy? _____

What was mother's general attitude during pregnancy? _____

Were there any disturbances within the family during the pregnancy (distressing family problems, living conditions, or marital difficulty)? Yes No

If yes, please explain:

During pregnancy did the mother have any of the following complications?

	Yes	No		Yes	No
Accidents or injury			Kidney Disease		
Infections			Malnutrition		
Anemia			Medications		
Chronic Illness			Placental Problems		
Convulsions/seizures			RH/(other incompatibilities)		
Diabetes			Spotting		
Emotional problems			Substance abuse		
Flu or virus			High fevers		
German measles			Thyroid problems		
Heart disease			Toxemia		
High blood pressure			Other complications		
Hormones					

Please explain the responses marked Yes:

Birth:
Was the pregnancy full term?_____If not, what was the length? _____

Where was the baby delivered? _____

How long was labor? _____

What was the baby's birth weight? ____ lb. ____oz.

Were there any complications during labor or delivery? Yes No

Please indicate any of the following:

	Yes	No
Accelerated heart rate		
Lack of oxygen		
Anesthesia		
Meconium staining		
Breech presentation		
Medication		
Cesarean section		
Multiple birth		
Induced labor		
Premature labor		
Forceps		
Other complications		

Please explain the responses marked Yes:

In the first few days after birth, did the baby have any of the following? Yes No

	Yes	No
Blood transfusions		
Phototherapy (lights)		
Bluish-gray color		
Positive for drugs		
Breathing difficulties		
Respirator		
Bruises		
Special care nursery/NICU		
Convulsions/seizures		
Withdrawal symptoms		
Infection		
Yellow jaundice		
Other complications		

Please explain the responses marked Yes:

Infancy:

During infancy, the baby was: sleepy/quiet moderately active very active

During infancy, the baby was: unfriendly shy friendly

During infancy, the baby preferred: little some a lot of physical contact

During infancy, the baby was: breast fed bottle fed both

Was the baby hard to feed? Yes No

Was the baby colicky? Yes No For how long?_____

Please describe any problems with feeding (sucking, swallowing, vomiting, etc.):

How old was the baby when weaning occurred? _____

Were there any difficulties when weaning occurred? _____

How old was the baby when solid foods were introduced?_____

How old was the baby when teething began?_____

Developmental Milestones:
Please list the **approximate** age the baby/child was able to perform the following (if it was typical, you may say "on time" or "within normal limits"):

Motor Skills:	Age:	**Language Skills:**	Age:
Sat without help		Spoke first word	
Crawled		Named objects	
Walked unassisted		Used sentences	
Ran			
Fed self		**Cognitive Skills:**	Age:
Dressed self		Knew name	
Rode tricycle		Recited ABCs	
Tied shoes		Recognized colors	
		Counted to 10	

Has there been any decrease in or loss of previously acquired abilities? Yes No
If yes, please explain:

Toilet Training:
How old was the child when toilet training was initiated? _____

Completed? _____

Please describe how the child was toilet trained and any special reaction the child had toward the training:

Has there been any day wetting, bed wetting, or soiling since toilet training was completed? Yes No

If yes, specify which and tell when it began, how frequently it occurred, whether it stopped or is still present:

Childhood Behaviors:

Below is a list that describes childhood behaviors. Check yes or no for each item that has applied or does apply to your child.

	Yes	No	Age/Duration:
Breath holding			
Hair pulling			
Rocking			
Head banging			
Overly sensitive to sounds			
Tics			
Sleep walking			
Night terrors			
Tantrums (beyond what is developmentally appropriate)			
Imaginary friends			
Removes/d self from group			

Please explain:

Sleeping:

What are the present sleeping arrangements for the patient (shares bed with parent? Sibling?)

Does the patient have any sleep difficulties? Does s/he sleep too much? Not enough? Have trouble falling or staying asleep? Has s/he ever? Please describe.

Eating:
What is the patient's relationship to food? Is s/he a good eater? Picky? Does s/he make good food choices?

Is there any history of eating disorders?

Moves:
List all moves during the patient's lifetime and describe any problems related to adjusting to the new home, neighborhood, or school. Give the age of the child for each move.

Have there been any prolonged separations from one or both parents? Yes No
List each, describing reason for separation, length of separation, and age of child when the separation took place.

Other than the child's parents, who have been significant caretakers (list whom, when, and for how long)?:

Medical Information

Pediatrician/Doctor:
Name:_____

Address:_____

Phone Numer:_____

Is the patient treated for any chronic medical conditions? Yes No

Please Explain:

Has the patient ever had surgery or been hospitalized? Yes No
If yes:

Problem	Date	Duration of Stay

Has the patient ever had any of the following?

	Yes	No
Neurologic problems, seizures, tics, migraines		
Heart or circulatory problems including high blood pressure		
Eye problems (glasses/contact lenses)		
Urinary or kidney problems		
Cancer or related illnesses		
Thyroid or other endocrine or metabolic problems (e.g. diabetes)		
Stomach or digestive problems, including eating/ weight problems		
Problems of anemia or blood disorder		

If yes, please explain below:

Medication Information

Is the patient currently taking any medications? Yes No

If yes, please list:

Name	Dose	Prescribing Doctor and Duration of time

Please list any **allergie**s and treatment:

Educational Information

Please list schools attended and the patient's progress at each (end with current school):

School Name	Years/Grades Attended	Achievement Level/ GPA

Were there academic problems reported? Yes No

Were there behavior problems reported? Yes No

Please indicate whether the patient has had any involvement in the following:

	Yes	No	When?
Psychoeducational Evaluation			
Committee on Special Education Classification*			
Individualized reading program (e.g. Orton)			
Speech/Language therapy			
Occupational Therapy			
Basic skills in school			
Special education classes			
IEP			
504 Plan*			
Tutoring outside of school			
Difficulty completing HW			
Attendance issues			
Behavior Plan			

***If yes, please specify the dates/grade level and IEP classification (e.g. SLD, OHI) or justification for 504:**

If yes to any of the other categories please explain:

Psychiatric Information

Has the patient had previous counseling, therapy, or psychiatric treatment? Yes No

Name of Therapist	Dates of Treatment	Frequency of visits (e.g. 1x/wk)	Type of treatment (e.g. individual, group, family)

Family History:

Is there a **family history** of psychiatric/psychological/learning problems? Yes No

Please explain (e.g. brother has ADHD, treated with medication; paternal grandfather – undiagnosed depression and alcoholism):

Does the patient use drugs or alcohol? _____

Has the patient ever been hospitalized? Yes No

If yes, list where, duration of treatment, nature of diagnosis/problem, and modality (e.g. individual, group, family):