Lifestages
Family Neurohealth

Date of Eval:

I. Identifying & Demographic Information

A. Information About Your Child

Child's Name: _____

(Last) (First) (Middle)

Child's Date of Birth:_____Child's Age:_____Child's Sex (circle): F M

Child's Current Address: _____

_____

_____

Home Phone #: _____

School:_____ Grade: _____

Handedness: _____

Child's Ethnicity: African American Asian Caucasian

Hispanic Other (Specify) _____

Language(s) spoken at home: _____

Is child adopted: Yes No

If yes, where from and at what age: _____

Is Child currently living with both parents: Yes No
If no, which parent is child living with: _____

Who has legal custody of the child: _____

Marital Status of the primary caregiver(s):

_____Single _____Separated: how long_____

_____Married _____Divorced; Date of divorce_____

_____Cohabitating

B: Referral Information

Who referred you to our service?

Name: _____

Profession:_____

Address:_____

Phone Number: _____

C: Family History

1. Biological mother: _____ Age: _____

   Education:_____ Occupation: _____

   Other phone numbers: _____

   Email: _____

2. Biological father:_____ Age: _____

   Education:_____ Occupation: _____

   Other phone numbers: _____

   Email: _____

3. Step/Foster/Adopted Parent:_____Age: _____

   Education:_____ Occupation: _____

   Other phone numbers: _____

   Email: _____

4. Step/Foster/Adopted Parent:_____Age: _____

   Education:_____ Occupation: _____

   Other phone numbers: _____

   Email: _____

5. Additional children and other family members living with the family:

Name:	Age:	Medical/social/school problems

6. Child's biological families medical/psychological history

Mother's side of family:

_____learning problems _____school problems _____attention/concentration problems

_____hyperactivity _____anxiety _____obsessive compulsive disorder

_____depression _____mental handicap _____alcoholism/drug abuse

_____bipolar disorder _____seizure disorder _____developmental disability

_____genetic disorder _____head injury _____autism/Asperger's syndrome

_____metabolic disease _____other condition (specify) _____

Father's side of family:

_____learning problems _____school problems _____attention/concentration problems

_____hyperactivity _____anxiety _____obsessive compulsive disorder

_____depression _____mental handicap _____alcoholism/drug abuse

_____bipolar disorder _____seizure disorder _____developmental disability

_____genetic disorder _____head injury _____autism/Asperger's syndrome

_____metabolic disease _____other condition (specify) _____

II: Presenting Problem

1. What concerns do you have about your child and why are you currently seeking help?

2. What type of information or assistance are you hoping to attain from the evaluation?

3. Does your child have any school behavior problems? (If yes, please describe)

4. Does your child have any studying and/or learning problems? (If yes, please describe)

5. Please list three of the child's strengths:

1. _____

2. _____

3. _____

6. Please list three of the child's weaknesses:

1. _____

2. _____

3. _____

III: Previous Evaluations

A. Has your child ever received any of the following evaluations: psychological, neuropsychological, educational, speech/language, neurological, or other types of evaluations? (Indicate where, when, and by whom these were done). Additionally, please attach copies of reports from the previous evaluations to this form.

With Whom: Date: Location: Reason for Evaluation:

Has your child ever received physical therapy: Yes No

If yes, with whom, when, for how long, where, and why?

Has your child ever received occupational therapy: Yes No

If yes, with whom, when, for how long, where, and why?

Has your child ever received speech and language therapy: Yes No

If yes, with whom, when, for how long, where, and why?

Has your child ever been tested by an audiologist: Yes No

If yes, with whom, when, for how long, where, and why?

V: Developmental History

A. Pregnancy and Birth History

How many weeks did the pregnancy last (normal is 38-42 weeks): _____

Please list any medications taken during the pregnancy:

Medication	Months taken (of 9)	Dose	Reason for taking

Was alcohol consumed during the pregnancy: Yes No

Was smoking or tobacco used during the pregnancy: Yes No

Were any illicit drugs (e.g., marijuana, cocaine) used: Yes No

Were there any illnesses during the pregnancy: Yes No

If yes, please describe _____

Were there any traumas during the pregnancy: Yes No

If yes, please describe_____

Was there any exposure to chemical, toxic substances,

or people with infections during the pregnancy: Yes No

If yes, please describe_____

Were there any difficulties with the child during

or immediately after birth: Yes No

If yes, please describe_____

Birth Weight:_____lbs._____oz

Birth Length:_____inches

Apgar score: First_____Second_____

Developmental Milestones

Please list age *in months* for each milestone achieved (approximate if not sure)

_____rolled over	_____first word	_____ability to hold crayon to color
_____sat alone	_____first sentence	_____bladder trained at night
_____crawled	_____walked	_____bowel trained
_____understood no	_____peddled a tricycle	_____bladder trained during the day

Please describe your child's behavior, temperament, and social functioning as a toddler, infant, and preschooler:

_____

_____

_____

_____

_____

_____

_____

_____

School Experiences

Schools Attended	Grades	Academic Concerns	Behavioral Concerns
Preschool			
Kindergarten			
Elementary School			
Middle/Junior High			
High School			
Post High School			

Please describe any concerns that you have regarding your child's performance within the academic setting (grades, academics, and/or behavior):

Did or does your child receive early intervention services: Yes No

If yes, please explain: _____

To the best of your knowledge, at what grade level is your child currently performing?

Reading: _____ Math: _____ Writing: _____

Has your child ever been held back or has grade retention ever been suggested?

Yes No

If yes, please explain: _____

Has your child ever received special education services or received academic accommodations through a 504 Plan? Yes No

If yes, please explain: _____

_____

_____

_____

_____

Please attach a copy of your child's most recent Individualized Educational Plan (IEP) or 504 to the back of this form.

Does your child receive any of the following in school?

_____adapted physical education _____physical therapy

_____occupational therapy _____speech therapy

_____counseling/social work _____academic tutoring

Does your child receive private academic tutoring? Yes No

If yes: With who, how often, when did it begin, and what is the focus:

_____

_____

_____

_____

About how much time each night does your child spend doing homework? _____

Does your child participate in any extra-curricular activities at school (sports/clubs)?

Yes No

If yes, what are they: _____

_____

_____

Social History

Does your child actively seek out friends? Always Often Sometimes Never

Do other children seek out your child? Always Often Sometimes Never

Does your child relate well to others? Always Often Sometimes Never

Does your child understand social rules? Always Often Sometimes Never

What are the ages of the majority of your child's friends:

_____Same age _____Older _____Younger

Does your child exhibit difficulties with friendships? Yes No

If yes, please explain: _____

_____

_____

Does your child exhibit difficulties with play behavior? Yes No

If yes, please explain: _____

_____

_____

What does your child enjoy doing the most? _____

_____

_____

_____

Mental Health History

Has your child ever received outpatient psychotherapy counseling? Yes No

Therapists: _____

Diagnoses: _____

Duration of treatment: _____

Response to treatment: _____

Medical History

Primary care physician: _____ Phone Number: _____

Current height: _____ Current weight: _____

Current medical problems for which your child is being treated: _____

_____

_____

Has your child ever had frequent ear infections? Yes No

Did he/she have pressure equalizing tubes placed? Yes No

If yes, age at time of surgery: _____

Does your child have hearing problems? Yes No

If yes, please explain: _____

_____

Has your child ever received an audiological evaluation? Yes No

Date: _____ Results: _____

Has your child received an ophthalmologic evaluation or vision screening?

Yes No

Dates: _____ Results: _____

Does your child use or require special equipment? Yes No

Please explain: _____

_____

Has your child used:
_____ Alcohol _____Cigarettes _____Drugs

If so, please explain: _____

_____

Has your child been a victim of emotional, physical, or sexual abuse? Yes No

If yes, please explain: _____

_____

_____

Has your child ever received acute psychiatric care? Yes No

Program:_____ Dates of attendance: _____

Has your child ever attended Residential or Day Treatment Programs? Yes No

Program:_____ Dates of attendance: _____

Program:_____ Dates of attendance: _____

Program: _____ Dates of attendance: _____

Have you used in-home services? Yes No

If yes, please explain: _____

_____

_____

_____

Medication History

On average, how often does your child receive his/her medication in the correct dosage?

a. Less than 50% of the time

b. 50-80% of the time

c. 81-100% of the time

Is your child responsible for taking any doses of medication? Yes No

Are medications supervised? Yes No

Is the school responsible for giving doses of medications? Yes No

Please list all past and present medications prescribed and the dosages:

Medication	Prescribed by	Dosage	Date started/ended	Response/side effects

Additional Comments: _____

_____

_____

_____

_____

Name of person completing this form: _____

Relationship to child: _____

OPTIONAL

How did you hear about our facility?

- o Doctor Referral
- o Friend
- o Online
    - o Facebook
    - o Google Search
    - o Yahoo Search
    - o Other: _____
- o Billboard/Signage

  If so, where? _____
- o Other:_____

Thank you for your cooperation and patience in completing this form!