Intake Parent Questionnaire

A Note Before You Begin.
I'm looking forward to working with you and your child, and to supporting your family throughout this process. The following background questionnaire is an important first step. I understand that it's a lengthy form and may take some time to complete, but your detailed responses are essential for building a full understanding of your child's history, strengths, challenges, and current concerns. Your input will help me prepare thoroughly for the evaluation and tailor the process to meet your child's individual needs. Thank you for taking the time to complete this form thoughtfully—your insights truly make a difference in the care I can provide.

Date of form completion:

Child Information

Full name:

Date of birth: Age:

Handedness: ☐ Right ☐ Left ☐ Both

Person Completing This Form

Full name:

Relationship to child:

Home address:

Phone number:

Best time to contact you: ☐ Morning ☐ Afternoon ☐ Evening

Who recommended this evaluation

☐ Parent/Guardian (Self) ☐ Physician ☐ Primary care doctor ☐ Teacher ☐ Therapist ☐ Other:

Name of referring provider or school staff (if applicable):

Reason for Referral

What concerns do you have, and what are you hoping to learn or better understand about the child through this process?

Primary Concerns

Please list up to 3 major concerns you have about the child.

Concern	When first noticed	Who noticed	What has been tried

Pediatric Neuropsychology Associates PLLC
2699 Stirling Rd Suite C306C, Ft. Lauderdale, FL 33312
admin@pediatricneuropsychologyassociates.com

Primary Weaknesses

Please list up to 3 major areas where the child struggles.

Concern	When first noticed	Who noticed	What has been tried

Primary Strengths

Please list 2–3 major strengths the child demonstrates.

1.

2.

3.

Family History

Is the child:

☐ Biological ☐ Adopted ☐ Fostered

If adopted or fostered:

Who adopted/fostered the child?

At what age?

What is the marital status of the child's caregivers:

☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other:

If divorced or separated, in what year did this occur?

If the child has always been raised by a single parent, please explain:

Please list everyone in the child's immediate family, including biological, step, half, or foster family members, significant others, or others living in the household or involved in caregiving

Name	Relationship to child	Age	Lives with the child
			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes

If the child's caregivers are no longer living together:

What is the child's current living situation (e.g., time in each household, schedule)?

Who lives with the child in each household?

Household 1:

Household 2:

What is the child's current custody arrangement?

☐ Sole custody to one parent ☐ Joint custody ☐ Split custody ☐ Physical w/ one, legal shared ☐ Other:

Who has legal rights for:

Medical and health decisions:

Educational decisions:

Mental health/psychological care:

What is each parent/caregiver's involvement in the child's life?

Caregiver name	Daily Visits	Weekly Visits	Weekly Calls	Financial Only	Other
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

If one parent or caregiver is not involved:

When did this start?

When did the child last see them?

Have parental rights been legally terminated or restricted? ☐ No ☐ Yes

If yes, please explain which rights and provide court documentation:

Has ACS (Administration for Children's Services) or CPS (Child Protective Services) been involved with the child? ☐ No ☐ Yes

If yes, explain when and why:

Are there any past, present, or future legal issues relevant to this evaluation (e.g., fall, accident/injury, custody dispute, medical injury)? ☐ No ☐ Yes

If yes, please explain:

Are there any recent changes or stressors in the child's life that may affect their emotional, behavioral, social, or cognitive functioning?

Family:

☐ New sibling ☐ Separation/divorce ☐ Loss of family member ☐ Other:

School:

☐ New teacher ☐ Bullying ☐ Other:

Home:
☐ Parental job changes ☐ Financial instability ☐ Housing issues ☐ Other:

Health:
☐ Illness ☐ Death ☐ Hospitalization ☐ Other:

Biological mother's highest level of education:
☐ Grades 1–8 ☐ Grades 9–11 ☐ HS grad/GED ☐ 1–2 yrs college ☐ Associate's
☐ 3–4 yrs college ☐ Bachelor's ☐ Graduate school ☐ Graduate degree
Current employment and occupation:

Biological father's highest level of education:
☐ Grades 1–8 ☐ Grades 9–11 ☐ HS grad/GED ☐ 1–2 yrs college ☐ Associate's
☐ 3–4 yrs college ☐ Bachelor's ☐ Graduate school ☐ Graduate degree
Current employment and occupation:

Please list any family members (including grandparents, parents, aunts, uncles, cousins, siblings etc.) with a history of the following:
• Medical problems: e.g., Seizures, stroke, dementia, cancer, diabetes, hypertension, heart conditions, Parkinson's disease etc.
• Neurodevelopmental disorders: Autism, intellectual disability, ADHD, learning disorders etc.
• Behavioral problems: Explosive outbursts, legal issues, substance abuse etc.
• Emotional/mental health issues: Depression, anxiety, PTSD, bipolar disorder, schizophrenia etc.
• Cognitive issues: memory, attention, or language difficulties etc.
• School problems: e.g., reading, writing, or math problems etc.

Family Member	Relationship	Area of Concern

Are there any family members (e.g., parents, grandparents, siblings, aunts, uncles) who are left-handed or mixed-handed?
☐ No ☐ Yes
If yes, who:

Language History

What language(s) has the child been exposed to?
☐ English ☐ Spanish ☐ Mandarin ☐ Arabic ☐ French ☐ Other:
If more than English, specify when first exposed (age/time period) and how long:

What language(s) does the child use most often?
☐ English ☐ Spanish ☐ Mandarin ☐ Arabic ☐ French ☐ Other:
Mix of languages (please explain):

What language(s) are spoken at home?
☐ English ☐ Spanish ☐ Mandarin ☐ Arabic ☐ French ☐ Other:
If more than English, explain which and with whom:

What language(s) are spoken at school?
☐ English ☐ Spanish ☐ Mandarin ☐ Arabic ☐ French ☐ Other:
If more than English, explain which and with whom:

What language(s) does the child use for media?

☐ English ☐ Spanish ☐ Mandarin ☐ Arabic ☐ French ☐ Other:

If more than English, explain which and for what media:

Which language do you think the child understands the best?

☐ English ☐ Spanish ☐ Mandarin ☐ Arabic ☐ French ☐ Other:

If more than one, explain:

Which language do you think the child speaks the best?

☐ English ☐ Spanish ☐ Mandarin ☐ Arabic ☐ French ☐ Other:

If more than one, explain:

Which language do you think the child reads the best?

☐ English ☐ Spanish ☐ Mandarin ☐ Arabic ☐ French ☐ Other:

If more than one, explain:

What form(s) of communication does the child use?

☐ Spoken language ☐ Sign language ☐ PECS ☐ AAC device ☐ Other:

If combination, describe when/how each is used:

Approximately how many words or signs does the child use independently (across all communication modes, e.g., spoken, signs, AAC)?

☐ Less than 10 ☐ 10–50 ☐ 50–100 ☐ 100–250 ☐ More than 250 ☐ Unsure

Does the child understand language better than speak it?

☐ No ☐ Yes ☐ About the Same ☐ Unsure

Pregnancy & Birth History

Was the child part of a multiple birth (twin, triplet)? ☐ No ☐ Yes

Was conception medically assisted (e.g., IVF, IUI, fertility medications)? ☐ No ☐ Yes

Please describe:

Biological mother's age at delivery: Biological co-parent's age:

Did the biological mother receive regular prenatal care? ☐ No ☐ Yes

Was the pregnancy high risk?

☐ No ☐ Yes ☐ Not Sure

Were there maternal complications, illnesses, medical conditions before or during pregnancy? ☐ No ☐ Yes

Please list conditions (e.g., high blood pressure, diabetes, epilepsy, thyroid condition, depression):

Were any medications taken during pregnancy? ☐ No ☐ Yes

Please list medications and what they were taken for:

Did the biological mother use any of the following during pregnancy (including before she knew she was pregnant)?
(? = Don't Know, D = Day, W = Week, M = Month)

Substance	Used?	Amount	Per	Trimester(s)
Tobacco	☐ No ☐ Yes ☐ ?		☐ D ☐ W ☐ M	
Alcohol	☐ No ☐ Yes ☐ ?		☐ D ☐ W ☐ M	
Other substances	☐ No ☐ Yes ☐ ?		☐ D ☐ W ☐ M	

Abnormalities on prenatal ultrasounds or screenings? ☐ No ☐ Yes

Please describe:

Were there any pregnancy complications (e.g., gestational diabetes, preeclampsia, high blood pressure)? ☐ No ☐ Yes

Please describe:

Was the child born:

☐ Full-term (37–40 wks) ☐ Pre-term (<37 wks) ☐ Post-term (>40 wks)

If pre/post-term, gestational age: ☐

Type of delivery:

☐ Vaginal ☐ Induced ☐ Planned C-section ☐ Emergency C-section ☐ Other: ☐

Were there any complications during delivery (e.g., long/hard labor, labor not progressing, problems with the umbilical cord, not normal baby heart rate, respiratory distress, blue baby, breech, fetal distress, hemorrhage, meconium aspiration, water broke early)?

☐ No ☐ Yes

Please describe:

Apgar 1 min: ☐ 5 min: ☐

Birth weight lbs: ☐ oz: ☐

Were there any medical issues immediately after birth?

☐ No ☐ Yes

☐ Jaundice ☐ Low oxygen ☐ Low blood sugar ☐ Seizures ☐ Blue baby ☐ Other: ☐

☐ Infection ☐ Cord around neck ☐ Poor muscle tone ☐ Respiratory distress

Please describe:

Medical interventions required?

☐ No ☐ Yes

☐ Oxygen ☐ Incubator ☐ Blood transfusion ☐ Ventilator ☐ Other: ☐

Please describe:

How long was the baby in the hospital after delivery (days)?

NICU stay required? ☐ No ☐ Yes

Was the child diagnosed with any medical or genetic condition(s) at or shortly after birth? ☐ No ☐ Yes

Please list:

Did the child have exposure to secondhand smoke, lead, or other toxins during pregnancy or infancy?

☐ No ☐ Yes

Please describe:

Newborn hearing exam?

☐ Passed ☐ Failed ☐ Not Sure

Newborn eye exam?

☐ Passed ☐ Failed ☐ Not Sure

Feeding difficulties after birth? ☐ No ☐ Yes

Please describe:

Infant temperament:

☐ Easy to soothe ☐ Quiet ☐ Fussy ☐ Difficult to comfort ☐ Irritable ☐ Other:

☐ Over-sleepy ☐ Difficult to rouse ☐ Sickly

Developmental History

When did the child first achieve these milestones? (best estimate)

Gross Motor Skills	Age	Communication and Language Skills	Age
Rolled over		Smiled	
Sat up without support		Babbled	
Crawled		Responded to name	
Stood up without support		First word spoken	
Took first steps		Used two-word phrases	
Ran		Used full sentences	
Rode a bike (without training wheels)		Followed simple instructions	
		Name familiar objects or people	

Fine Motor Skills	Age	Toileting	Age
Picked up small objects		Bowel trained	
Stacked blocks		Bladder trained	
Held a crayon			
Drew or scribbled simple shapes			
Used utensils (spoon or fork)			
Dressed themselves			

Compared to other children the child's age, do they have difficulties/experience delays with any of the following?
If older, fill out what you remember when they were younger.

Play Concerns

- ☐ Limited interest in environment/people
- ☐ Plays with parts of toys (e.g., wheels)
- ☐ Plays same way over and over
- ☐ Limited pretend/imaginative play
- ☐ Plays with only limited toys
- ☐ Plays with toys atypically
- ☐ Repeats actions (spinning, flapping)
- ☐ Struggles to imitate others
- ☐ Other:

Social Engagement Concerns

- ☐ Avoidant or fleeting eye contact
- ☐ Difficulty with back-and-forth play
- ☐ Difficulty cooperating or sharing
- ☐ Prefers to play alone
- ☐ Seems unaware of others' emotions
- ☐ Struggles to initiate/maintain friendships
- ☐ Trouble in group activities
- ☐ Difficulty interpreting nonverbal cues
- ☐ Struggles to be affectionate
- ☐ Other:

Sensory Concerns

- ☐ Over/under-responsive to sounds, smells, textures
- ☐ Avoids grooming (haircuts, brushing)
- ☐ Chews/mouths non-food objects
- ☐ Head banging
- ☐ Seeks sensory input (crashes, chews)
- ☐ Unaware of pain or temperature
- ☐ Toe walking
- ☐ Other:

Eating Concerns

☐ Very picky eater ☐ Overeats ☐ Other:

Separation from Caregivers Concerns

- ☐ Very upset when separated from caregivers
- ☐ Clings excessively in unfamiliar settings
- ☐ Distressed when left alone in a room
- ☐ Difficulty falling asleep alone
- ☐ Other:

Difficulty with Changes or Breaking Routines

- ☐ Trouble adapting to change
- ☐ Struggles with unexpected changes
- ☐ Maintains strict routines
- ☐ Other:

Verbal Communication – Expressive – Concerns

- ☐ Makes strange or repetitive sounds
- ☐ Difficulty with pronunciation
- ☐ Trouble recalling/finding words
- ☐ Incorrect pronoun use
- ☐ Unusual tone of voice
- ☐ Repetitive nonsense sounds
- ☐ Repeats words instead of answering
- ☐ Limited vocabulary
- ☐ Difficulty forming sentences
- ☐ Trouble expressing thoughts/needs
- ☐ Talks to self often
- ☐ Other:

Verbal Communication – Receptive – Concerns

- ☐ Difficulty responding to name
- ☐ Difficulty answering questions
- ☐ Difficulty following 1–2 step directions
- ☐ Trouble understanding what others say
- ☐ Trouble understanding certain words
- ☐ Seems to 'tune out' when spoken to
- ☐ Other:

Nonverbal Communication Concerns

- ☐ Difficulty using gestures (pointing, showing)
- ☐ Difficulty understanding others' gestures
- ☐ Doesn't point to share interest
- ☐ Difficulty using facial expressions/body language
- ☐ Rarely smiles or shows emotions
- ☐ Rarely brings/shows objects to others

- [ ] Doesn't look when someone points
- [ ] Uses other's hands as tool
- [ ] Other:
- [ ] Difficulty imitating expressions/actions

Fine Motor Concerns

- [ ] Trouble picking up small objects
- [ ] Difficulty building with blocks
- [ ] Difficulty using scissors
- [ ] Other:
- [ ] Difficulty with drawing/coloring
- [ ] Difficulty dressing (buttons, zips, ties)

Gross Motor Concerns

- [ ] Difficulty sitting up independently
- [ ] Difficulty walking independently
- [ ] Problems with balance/coordination
- [ ] Other:
- [ ] Difficulty standing independently
- [ ] Difficulty climbing stairs

Toileting Concerns

- [ ] Frequent accidents despite trained
- [ ] Regression in toileting skills
- [ ] Other:
- [ ] Resistance to using toilet

Learning/Cognitive Concerns

- [ ] Difficulty learning shapes/colors/letters/numbers
- [ ] Difficulty solving basic problems
- [ ] Other:
- [ ] Difficulty paying attention

Overall Developmental Concerns Summary

Area	Concern?	Explain	When noticed	Trajectory
Play	☐ N ☐ Y			
Social Engagement	☐ N ☐ Y			
Sensory	☐ N ☐ Y			
Eating/Feeding	☐ N ☐ Y			
Gross Motor	☐ N ☐ Y			
Fine Motor	☐ N ☐ Y			
Behavior	☐ N ☐ Y			
Emotional	☐ N ☐ Y			
Cognitive	☐ N ☐ Y			

Has anyone suggested developmental delay? ☐ No ☐ Yes

Who and when:

Has the child ever lost previously acquired skills (regression), particularly in communication or social interactions (e.g., language loss, increased repetitive behaviors, loss of social interest)?

☐ No ☐ Yes

If yes, please describe:

Which hand does the child prefer?

☐ Right ☐ Left ☐ Not sure

Age when first noticed: ☐

Did the child qualify for Early Intervention (0-3)? ☐ No ☐ Yes

Service Type	Qualified	Received	Duration
Physical Therapy	☐ No ☐ Yes	☐ No ☐ Yes	
Occupational Therapy	☐ No ☐ Yes	☐ No ☐ Yes	
Speech/Language Therapy	☐ No ☐ Yes	☐ No ☐ Yes	
Developmental/Special Education Therapy	☐ No ☐ Yes	☐ No ☐ Yes	
Social Skills Therapy	☐ No ☐ Yes	☐ No ☐ Yes	
ABA	☐ No ☐ Yes	☐ No ☐ Yes	
Other	☐ No ☐ Yes	☐ No ☐ Yes	

Medical History

Has the child ever been diagnosed with any medical or genetic condition or illness?

Examples: stroke, brain tumor, cerebral palsy, spina bifida, kidney disease, liver problems, autoimmune disease, cancer, hypertension, thyroid disorder, congenital heart disease, diabetes, hydrocephalus, asthma, low birth weight, premature birth, leukemia, exposure to toxins, meningitis, encephalitis, seizures, staring spells, lead poisoning, Down syndrome, Fragile X syndrome, Turner syndrome.

☐ No ☐ Yes

If yes, please list below:

Diagnosis	Age at diagnosis	Treatment	Current status

Has the child ever had any seizures or convulsions? ☐ No ☐ Yes

When: ☐

Were the seizures/convulsions associated with a high fever? ☐ No ☐ Yes

Has the child ever been hospitalized (other than birth)? ☐ No ☐ Yes

Please explain (what, when, and for what reason):

☐

Has the child ever had any operations or surgeries? ☐ No ☐ Yes

Please explain (what, when, and for what reason):

☐

Has the child ever had a head injury? ☐ No ☐ Yes

When: ☐ What happened: ☐

Symptoms:

☐ Loss of consciousness ☐ Dizziness ☐ Headache ☐ Vomiting ☐ Other: ☐

Seen by physician? ☐ No ☐ Yes

Tests the child has had:

Test Type	Reason	Results
☐ CT/MRI		
☐ EEG		
☐ PET or SPECT		
☐ Spinal tap		
☐ Sleep study		
☐ Other:		

Has the child had any problems with the following?

Area of Concern	No/Yes	What is the problem?	Treatment	Trajectory
Vision *(myopia, hyperopia, astigmatism, etc.)*	☐ No ☐ Yes			
Hearing *(hearing loss)*	☐ No ☐ Yes			
Appetite *(picky eater, overeating)*	☐ No ☐ Yes			
Pain *(headaches, abdominal, muscle)*	☐ No ☐ Yes			
Ear infections	☐ No ☐ Yes			
Fainting spells	☐ No ☐ Yes			
Problems with sense of smell	☐ No ☐ Yes			
Fatigue or low energy	☐ No ☐ Yes			

Does the child use any assistive devices for vision or hearing?

☐ No ☐ Yes

If yes, please specify:

Has the child had a recent:

Vision exam?

☐ No ☐ Yes

Results:

Hearing exam?

☐ No ☐ Yes

Results:

How would you rate the child's current sleep quality?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Does the child have any of the following sleep problems?

☐ Wakes up during the night ☐ Screams during sleep ☐ Snores ☐ Trouble falling asleep ☐ Sleepwalks ☐ Bedwetting

☐ Thrashing during sleep ☐ Acts out dreams ☐ Other:

Does the child sleep in their own bed?

☐ No ☐ Yes

Typical sleep/wake times

Weekdays: Bedtime _____ / Wakes _____

Weekends: Bedtime _____ / Wake _____

Does the child have a regular bedtime routine?

☐ No ☐ Yes

Please describe: _____

Does the child have trouble waking up in the morning?

☐ No ☐ Yes

Please explain: _____

Does the child frequently feel tired during the day?

☐ No ☐ Yes

How often? _____

Does the child fall asleep at school?

☐ No ☐ Yes

How often? _____

Does the child take naps during the day?

☐ No ☐ Yes

How often and for how long? _____

Does the child engage in regular physical activity or exercise?

☐ No ☐ Yes

How often? _____

Does the child consume caffeine?

☐ No ☐ Yes

How often? _____

Does the child take any medications?

☐ No ☐ Yes

If yes, please complete the table below:

Medication name	Dosage	How often	Reason for medication	Results	Side effects

Do you (or another caregiver) experience any difficulty giving the child their medications?

☐ No ☐ Yes

If yes, please describe the challenges or barriers (e.g., child refusal, financial, transportation, insurance coverage, pharmacy issues):

_____

If the child is old enough, do they have a clear understanding of why they take their medications and the importance of taking them regularly?

☐ No ☐ Yes ☐ Not Sure

Who manages the child's medications?

☐ Parent/Caregiver ☐ Child (independently) ☐ Shared responsibility between caregiver and child ☐ Other: _____

On a scale of 1 to 10, where 1 is never and 10 is always, how consistently does the child take their medications?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Emotional History

General mood:

☐ Happy ☐ Sad ☐ Anxious ☐ Angry ☐ Frustrated ☐ Fearful ☐ Excited

☐ Other:

If anything other than 'generally happy,' what situations or events trigger these moods?

What strategies have helped manage the child's moods?

Have others expressed concerns about the child's mood? ☐ No ☐ Yes

If yes, please explain:

Does the child's mood impact their daily functioning (e.g., school, sleep, relationships)? ☐ No ☐ Yes

If yes, please explain:

How does the child typically cope with stress or difficult emotions?

☐ Uses relaxation techniques (e. ☐ Seeks comfort from others

☐ Withdraws/isolation ☐ Engages in physical activity

☐ Other:

Compared to other children their age, does the child struggle with any of the following?

Depressive Symptoms

☐ Frequent sadness or crying
☐ Fatigue
☐ Irritable
☐ Social isolation
☐ Frequent mood changes
☐ Changes in sleep/appetite
☐ Difficulty concentrating/deciding
☐ Other:
☐ Low energy
☐ Feeling down or blue
☐ Low motivation
☐ Low interest in activities
☐ Frequent temper outbursts
☐ Excessive guilt/self-blame

Anxiety Symptoms

☐ Excessive worrying
☐ Clinginess or fear of separation
☐ Fatigue or difficulty sleeping
☐ Avoids certain situations
☐ Perfectionism or fear of mistakes
☐ Other:
☐ Frequent fears (dark, alone)
☐ Distress in new situations
☐ Stomachaches/headaches without cause
☐ Racing thoughts/trouble concentrating

Self-Esteem Symptoms

☐ Negative self-talk
☐ Fear of failure
☐ Perfectionism
☐ Low confidence in social settings
☐ Withdrawn/isolated
☐ Sensitive to embarrassment
☐ Body image concerns
☐ Says 'nobody likes me'
☐ Overly self-critical
☐ Avoids challenges
☐ Compares self negatively
☐ Rejects praise
☐ Seeks constant reassurance
☐ Self-blaming
☐ Slouches/avoids eye contact

☐ Other:

Eating Behavior Symptoms

☐ Preoccupation with food/weight/calories
☐ Binge eating
☐ Excessive exercise
☐ Intense fear of gaining weight
☐ Distorted body image
☐ Other:
☐ Strict dieting
☐ Purging behavior
☐ Avoids eating around others
☐ Feels out of control around food

Overall Concerns

Present Concern	Please explain	When first noticed	Trajectory (e.g., improved, worsened, stable, unsure)
☐ No ☐ Yes			

Has the child ever been evaluated and/or diagnosed with a behavioral health disorder or neurodevelopmental disorder (e.g., depression, anxiety, oppositional defiant disorder, ADHD, autism, etc.)?

☐ No ☐ Yes

If yes, which diagnosis(es), and when?

Hospitalized or in treatment program for emotional/behavioral concerns? ☐ No ☐ Yes If yes, when/for what:

Has the child ever seen a therapist, psychologist, or counselor? ☐ No ☐ Yes If yes, when/why:

Prescribed medication for a behavioral health condition? ☐ No ☐ Yes If yes, when/why:

Does the child currently see a:

☐ Psychiatrist (med mgmt) ☐ Therapist/Counselor ☐ Neither ☐ Not sure

Behavioral History

Describe the child's general behavior:

Concerns about the child's behavior?

☐ No ☐ Yes

If yes, please describe specific behaviors:

Can you describe what typically happens before, during, and after these behaviors?

Before: During: After:

What triggers or situations seem to make these behaviors more likely to occur or worse?

☐ Specific people ☐ Certain locations ☐ Specific tasks/demands ☐ Transitions/changes in routine
☐ Sensory overload (e.g., noise, lights) ☐ Other:

Does the child ever display any physical aggression?

☐ No ☐ Yes

If yes:

☐ Kicking ☐ Hitting ☐ Biting ☐ Throwing objects ☐ Scratching ☐ Pushing ☐ Other:

Have other adults mentioned any concerns about the child's behavior?

☐ No ☐ Yes

If yes, who and what were the concerns?

How do others respond when these behaviors occur?

☐ Redirect ☐ Consequences ☐ Remove child ☐ Ignore ☐ Use rewards ☐ Seek help ☐ Other:

Is discipline consistent across adults?

☐ No ☐ Yes

If no, please explain:

What strategies have been helpful in managing the child's behavior?

☐ Positive reinforcement ☐ Time-outs ☐ Clear rules ☐ Behavior charts ☐ Therapy ☐ Other:

Does the child's behavior impact their daily activities (e.g., school or social interactions)?

☐ No ☐ Yes

If yes, please explain:

Where do these behaviors occur most often?

☐ Home ☐ School ☐ Public ☐ Other:

Compared to other children their age, does the child struggle with any of the following?

Disruptive Behaviors

☐ Frequent tantrums/anger outbursts
☐ Refuses to follow rules
☐ Blames others
☐ Easily irritated
☐ Destroys others' property
☐ Stealing
☐ Argues with adults/authority
☐ Deliberately annoys others
☐ Spiteful or vindictive
☐ Aggression to people/animals
☐ Dishonesty
☐ Sudden aggression episodes

Overall Behavior Concerns

Present Concern	Please explain	When first noticed	Trajectory (e.g., improved, worsened, stable, unsure)
☐ No ☐ Yes			

Social History

Does the child initiate conversations with others?

☐ No ☐ Yes

Does the child have problems making and keeping friends?

☐ No ☐ Yes

If yes, please explain:

Does the child have friends inside and outside of school?

☐ No ☐ Yes

If yes, how often do they get together:

Does the child generally get along with peers?

☐ No ☐ Yes

How does the child handle conflicts or disagreements with peers?

☐ Walks away ☐ Gets upset ☐ Tries to solve the problem ☐ Seeks help from an adult ☐ Other:

Does the child appear overly shy or anxious in social situations?

☐ No ☐ Yes

If yes, please describe:

How does the child interact with unfamiliar children?

☐ Avoids interaction ☐ Hesitant but warms up ☐ Engages easily ☐ Other:

Does the child have difficulty understanding social cues (e.g., tone of voice, facial expressions, body language)?

☐ No ☐ Yes

If yes, please explain:

Does the child prefer to play with others rather than alone or next to others?

☐ No ☐ Yes

Does the child try to share interesting or new things with others?

☐ No ☐ Yes

Which age group does the child prefer to play with?

☐ Younger ☐ Same age ☐ Older ☐ No preference

Has the child experienced bullying, teasing, or social exclusion?

☐ No ☐ Yes

If yes, please explain:

Does the child have difficulty participating in group activities?

☐ No ☐ Yes

If yes, please explain:

What does the child like to do for fun?

What extracurricular activities, hobbies, or clubs is the child involved in?

Independent Functioning History

Does the child have difficulty completing daily living skills (e.g., hygiene, eating, dressing, laundry)?

☐ No ☐ Yes

If applicable, does the child struggle with any of the following?

☐ Keeping track of belongings ☐ Completing homework ☐ Managing schedule ☐ Managing money
☐ Cooking ☐ Driving ☐ Making simple purchases ☐ None of the above

If applicable, can the child navigate the community independently (e.g., take public transportation, ask for help, follow directions)?

☐ No ☐ Yes

If no, please describe:

What household responsibilities or chores is the child responsible for?

How well do they complete them?

☐ Independently and well ☐ Independently but inconsistent ☐ Needs help ☐ Does not complete

How well does the child understand safety rules and instructions?

☐ Very well ☐ Adequately ☐ Poorly

If younger, can the child identify potential dangers (e.g., sharp objects, street crossings, strangers)?

☐ No ☐ Yes

If younger, does the child have a tendency to wander or wander away from you?

☐ No ☐ Yes

Does the child currently work or volunteer?

☐ No ☐ Yes

If yes, what do they do? _____

How often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally

Intervention History

Has the child ever received any of the following supports/therapies?

Type of service	Received	Ages received	Frequency (times/week)	Skills worked on	If discontinued, why?
Physical Therapy	☐ No ☐ Yes		☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		
Occupational Therapy	☐ No ☐ Yes		☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		
Speech and Language Therapy	☐ No ☐ Yes		☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		
Vision Therapy	☐ No ☐ Yes		☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		
Developmental Therapy	☐ No ☐ Yes		☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		
Social Skills Therapy	☐ No ☐ Yes		☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		
Applied Behavioral Analysis	☐ No ☐ Yes		☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		
Family Therapy	☐ No ☐ Yes		☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		
Individual therapy	☐ No ☐ Yes		☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		
Individual Aide	☐ No ☐ Yes		☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		
Other (please explain)	☐ No ☐ Yes		☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		

Cognitive History

Compared to other children their age, does the child struggle with any of the following?

Attention/Concentration Concerns

- ☐ Cannot focus for more than a few minutes
- ☐ Makes careless errors
- ☐ Gets easily distracted
- ☐ Moves on from task without finishing
- ☐ Struggles to pay attention to details
- ☐ Hard time listening when spoken to
- ☐ Gets bored easily

Learning and Memory Concerns

- ☐ Repeats questions
- ☐ Trouble recalling conversations/events
- ☐ Needs info repeated multiple times
- ☐ Needs reminders to do things
- ☐ Trouble following multi-step directions
- ☐ Is forgetful
- ☐ Loses things
- ☐ Needs to read things multiple times
- ☐ Trouble remembering faces/names
- ☐ Frequently misplaces items

Language Concerns

- ☐ Trouble expressing thoughts/ideas/needs
- ☐ Trouble recalling certain words
- ☐ Struggles to respond correctly to questions
- ☐ Not clearly understood by others
- ☐ Hard time understanding what others say

Flexibility Concerns

- ☐ Hard time coping with routine changes
- ☐ Difficulty transitioning between tasks
- ☐ Gets stuck on ideas or topics
- ☐ Trouble with alternative solutions

Impulse Control Concerns

- ☐ Hard time thinking before doing
- ☐ Fidgets with hands or feet
- ☐ Always on the move
- ☐ Does not wait when others talk
- ☐ Says inappropriate things without meaning to
- ☐ Leaves seat when expected seated
- ☐ Is squirmy
- ☐ Hard time not talking out of turn
- ☐ Grabs/touches things without asking
- ☐ Rushes to complete work

Planning/Organization Concerns

- ☐ Trouble breaking large tasks into steps
- ☐ Difficulty planning day/schedule
- ☐ Organization difficulties
- ☐ Forgets to bring home assignments
- ☐ Hard time figuring what to start first
- ☐ Struggles to develop plan before starting
- ☐ Messy backpack/desk/work area
- ☐ Regularly loses items

Time Management Concerns

- ☐ Does not get things done on time
- ☐ Is not on time for things
- ☐ Runs out of time on tests/projects
- ☐ Shows up late to activities
- ☐ Difficulty estimating time left
- ☐ Does not start tasks right away
- ☐ Under/overestimates task duration
- ☐ Loses track of time
- ☐ Takes unusually long to get ready

Multitasking Concerns

- ☐ Trouble switching between tasks
- ☐ Must complete one task before another
- ☐ Overwhelmed with multiple instructions
- ☐ Trouble doing two things at once

Visual-Spatial Concerns

- ☐ Bumps into people or objects
- ☐ Hard time telling right from left
- ☐ Struggles with geometry/graphs
- ☐ Trouble reading maps or charts
- ☐ Trouble with reading/writing layouts
- ☐ Problems copying from board

Speed of Processing Concerns

- ☐ Takes long time to respond to questions
- ☐ Takes long time to complete tasks
- ☐ Struggles to keep up with fast conversations
- ☐ Requires things presented slowly
- ☐ Seems 'zoned out' during conversations

Abstract Reasoning Concerns

- ☐ Struggles with hypothetical situations
- ☐ Struggles to make inferences
- ☐ Trouble applying concepts to new situations
- ☐ Takes things very literally
- ☐ Struggles with abstract concepts

Self-advocacy Concerns

- ☐ Struggles to ask for help
- ☐ Rarely voices opinion/preferences
- ☐ Doesn't speak up in conflicts
- ☐ Doesn't express when overwhelmed
- ☐ Hesitates to speak up when unsure
- ☐ Struggles to explain needs
- ☐ Doesn't ask for accommodations
- ☐ Avoids asking for clarification

Overall Cognitive Concerns

Present Concern	Please explain	When first noticed	Trajectory (e.g., improved, worsened, stable, unsure)
☐ No ☐ Yes			

School History

Past School History

Schools Attended

Name of school	Grades attended	Private or Public
		☐ Private ☐ Public
		☐ Private ☐ Public
		☐ Private ☐ Public

Did the child attend preschool?

☐ No ☐ Yes

If yes: Age _____ Attendance: _____

☐ Full-time ☐ Half-day

Did the child attend kindergarten?

☐ No ☐ Yes

If yes: Age _____

Did the child receive early intervention or preschool services?

☐ No ☐ Yes

If yes, specify: _____

Has the child ever repeated a grade?

☐ No ☐ Yes

If yes: Grade(s) _____ Reason(s): _____

Have teachers ever identified academic issues (e.g., needs repetition, forgets easily, processes slowly)?

☐ No ☐ Yes

If yes: Specify what and when _____

Has the child ever failed a class?

☐ No ☐ Yes

If yes: subject(s)/grades? _____

Grades typically received over the years?

☐ Mostly A's (Excellent work, consistently high grades)
☐ Mostly B's (Good work, generally above average)
☐ Mostly C's (Average work, meets expectations)
☐ Mostly D's (Below average, struggles with material)
☐ Mostly F's (Failing or incomplete work)
☐ Mixed grades (Grades vary by subject or term)

Have grades varied over the years?

☐ No ☐ Yes

If yes: Explain _____

Standardized test scores over the years?

_____

Have standardized test scores varied over the years?

☐ No ☐ Yes

If yes: Explain _____

Has the child ever had an IEP or 504 Plan?

☐ No ☐ Yes

If yes: year/grade started? _____ Reason for eligibility: _____

Has the child been educated in a special education setting?

☐ No ☐ Yes

If yes, complete table below:

Grade	Type of Special Ed	Classroom Type	Classes in Resource	Classes Self-Contained	Classes Inclusion
		☐ Resource Room ☐ Self-Contained ☐ Inclusion/Co-Teaching ☐ Mixed			
		☐ Resource Room ☐ Self-Contained ☐ Inclusion/Co-Teaching ☐ Mixed			
		☐ Resource Room ☐ Self-Contained ☐ Inclusion/Co-Teaching ☐ Mixed			

Has the child received tutoring or other academic help (school or private)?

☐ No ☐ Yes

If yes, complete table below:

Grade	Type of Service	Skills Targeted	Frequency	Teacher:student ratio

Has the child received academic accommodations or modifications in the classroom (e.g., extra time, preferential seating)?

☐ No ☐ Yes

If yes, specify: _____

Has the child received school counseling?

☐ No ☐ Yes

If yes: Grade(s), reason _____

Has the child undergone prior school or psychological testing?

☐ No ☐ Yes

If yes, when? _____

Has the child ever been diagnosed with a learning disorder?

☐ No ☐ Yes

If yes, specify subject(s) and when: _____

Does the child have a history of school avoidance/refusal?

☐ No ☐ Yes

If yes, explain: _____

Has the child had frequent absences or tardiness from school?

☐ No ☐ Yes

If yes, explain:

Current School History

School name:

Grade:

IEP or 504 plan?

☐ No ☐ Yes

If yes, classification:

Classroom type:

☐ Self-Contained ☐ Inclusion/Co-Teaching classes ☐ General education classes

☐ Mixed: Please explain:

Services received?

Accommodations/modifications in the classroom (e.g., extra time, preferential seating)?

Child's attitude toward school?

What is the child's:

Best subject(s): Worst subject(s):

Most favorite subject(s): Least favorite subject(s):

What grades does the child receive? Please explain, which grades for which class.

Subject	Below/At/Above Grade Level	If Below, approx grade level	Current Mark
Math	☐ Below ☐ At ☐ Above	☐ Pre ☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 Other:	☐ A ☐ B ☐ C ☐ D ☐ F ☐ N/A Other:
Reading	☐ Below ☐ At ☐ Above	☐ Pre ☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 Other:	☐ A ☐ B ☐ C ☐ D ☐ F ☐ N/A Other:
Spelling	☐ Below ☐ At ☐ Above	☐ Pre ☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 Other:	☐ A ☐ B ☐ C ☐ D ☐ F ☐ N/A Other:
Written Expression	☐ Below ☐ At ☐ Above	☐ Pre ☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 Other:	☐ A ☐ B ☐ C ☐ D ☐ F ☐ N/A Other:
Science	☐ Below ☐ At ☐ Above	☐ Pre ☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 Other:	☐ A ☐ B ☐ C ☐ D ☐ F ☐ N/A Other:
Social Studies/Global History	☐ Below ☐ At ☐ Above	☐ Pre ☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 Other:	☐ A ☐ B ☐ C ☐ D ☐ F ☐ N/A Other:

Any homework concerns (e.g., turning it in on time, completing it independently)?

☐ No ☐ Yes

If yes, explain:

Describe the child's homework routine:

Teacher Information

What is the child's primary teacher's name?

What is the child's primary teacher's contact information? (email):

Additional Information

Any additional comments you think might be helpful for me to know?