Student Name:       Gender: [ ]  Male [ ]  Female

Current School:       Grade:       Date of Birth:

Parents Names:

Address:       Email:

Telephone: (Home)       (Cell)

**Legal Guardian Status (check at least one item)**

[ ]  Married [ ]  Adoptive Parents [ ]  Family/Children Services

 [ ]  Biological Mother [ ]  Adoptive Mother [ ]  Court \_\_\_\_\_\_\_\_\_\_\_

 [ ]  Biological Father [ ]  Adoptive Father [ ]  Other \_\_\_\_\_\_\_\_\_\_\_

**Marital Status of Parents (check at least one item)**

[ ]  Married [ ]  Single [ ]  Married, living apart

 [ ]  Divorced (check custody status)

 [ ]  Joint Custody [ ]  Sole Custody ([ ]  Mother [ ]  Father)

Does child have visitation with non-custodial parent? [ ]  Yes [ ]  No

List the names and ages of all people currently living at your child’s residence:

 Name Relationship to Child Age/Education Level Primary Language

What is the child’s primary language?

Are there other languages spoken in the home? If so, what languages:

**General Information:**

Briefly describe your child’s strengths:

In your opinion, why is your child being referred for evaluation:

**Medical History:**

**Pregnancy:**

Please describe any complications, medicines taken, or other concerns expressed during pregnancy (e.g., high blood pressure, toxemia, gestational diabetes, etc.)

**Birth/Delivery:**

Was the child full term? [ ]  Yes [ ]  No Duration of Pregnancy?

Cesarean Section? [ ]  Yes [ ]  No Birth weight?

Please described any complications with the birth/delivery or after delivery:

**Current Medical Status:**

Has your child had any serious injuries, illnesses, hospitalizations, surgeries, or traumatic events?

 Event Child’s age at time

**Current Medical Diagnoses:**  **Physician’s Name Date**

**Current Medications**

Medication Dosage Prescribing Physician and Date Prescribed

**Vision and Hearing:**

Date of last vision exam:       Results:

Vision problems: [ ]  YES [ ]  NO Glasses? [ ]  YES [ ]  NO Contacts? [ ]  YES [ ]  NO

Date of last hearing exam:       Results:

Hearing problems: [ ]  YES [ ]  NO Age Detected?

Hearing aids? [ ]  YES [ ]  NO Cochlear Implant? [ ]  YES [ ]  NO Date?

Tubes in ears? [ ]  YES [ ]  NO Date:

**Mental Health:**

Has the child ever been to a counselor, therapist, psychologist, or psychiatrists? [ ]  YES [ ]  NO

 If yes, please explain:

**Outside Evaluations:**

Has your child been evaluated outside of the public-school environment? [ ]  YES [ ]  NO

 If yes, by whom:

**\*\*Please attach a copy of the evaluation report.**

**Family History:**

Do you have a family history of any of the following? (biological parents, siblings, grandparents, aunts, uncles, cousins)

[ ]  Learning difficulties (reading, spelling, writing, math, organization)

[ ]  Speech or Language difficulties (articulation, stuttering, problem recalling words)

[ ]  Emotional difficulties (depression, anxiety, mood swings, psychosis)

[ ]  Cognitive difficulties (delays in reasoning or global learning)

[ ]  Genetic medical conditions (please explain below)

[ ]  Abuse or Domestic Violence (this includes abuse or violence the child has been the victim of as well as any the child has witness or is aware of within the home/family)

[ ]  Substance abuse (drug/alcohol)

Please describe any marked above:

**Developmental Information:**

 **Age Age Age**

Sat alone:       Spoke 1st word:       Toilet Trained:

Crawled:       Put several words together:       Dry at night:

Walked alone:       Spoke in complete sentences:

Please describe your child’s early temperament:

What concerns (if any) do you have regarding your child’s development or behavior?

Are there conditions at home that may be influencing your child’s development and/or behavior? (family illness, marital issues, etc.)

**Adaptive Behavior:**

Does your child have any difficulty or delay in the following areas? Check all that apply and describe in the space provided.

**Communication Skills**

**[ ]**  Making/producing speech sounds.

[ ]  Understanding language.

[ ]  Using language to communicate.

[ ]  Understanding social communication.

**Oral Motor Skills**

[ ]  Chewing solid food.

[ ]  Drinking from a cup.

[ ] Drinking through a straw.

[ ]  Excessive drooling.

[ ]  Swallowing problems.

[ ] Sensitivity to different textures of food/drink.

[ ] Sensitivity to different temperatures of food/drink.

**Motor Skills**

**[ ]** Walking.      **[ ]** Running.

**[ ]**  Jumping.

**[ ]** Climbing Stairs.

**[ ]** Walking on uneven surfaces.

**[ ]** Balance.

**[ ]** Manipulating small objects with his/her hands.

**[ ]** Using silverware or writing utensils.

**[ ]** Tying shoes, using zippers/buttons.

**Independent Living Skills** (Not all will be age appropriate, can mark if not expected to do)

[ ]  Feeding self.

[ ]  Dressing self.

[ ]  Personal hygiene.

[ ]  Toileting.

[ ]  Bathing self.

[ ]  Performing chores.

**Responses to Sensory Experiences:**

Does your child display any unusual or atypical behaviors, responses, or sensitivities in any of the following areas? This may appear as though the child is experiencing a sensation or feeling to a degree that doesn’t match the event or behaves in a way that seems “over the top” given the context of the situation.

[ ]  Taste.

[ ]  Smell.

[ ]  Movement. (walking around/moving in a clumsy manner)

[ ]  Tactile. (agitated or stimulated by certain fabrics/surfaces – touch/texture)

[ ]  Visual.

[ ]  Auditory/filtering. (a child who may be overwhelmed by sounds and cover their ears, or may need to have music or background sound on at all times)

[ ]  Activity level/weakness. (a child who seems overly active or severely tired and weak in a manner that does not fit their age, recent activity level or recent amount of sleep)

[ ]  Other (please describe)

**Patterns of Emotional Adjustment:**

Do you consider any of the following to be a problem for your child at this time? Check all that apply.

**Attention/Activity**

[ ]  Fidgets/easily distracted/hard time staying seated [ ]  Talks excessively/interrupts often

[ ]  Very disorganized compared to same aged peers [ ]  Poor concentration

[ ]  Difficulty following instructions [ ]  Difficulty initiating or completing tasks

**Emotional**

**[ ]**  Often depressed or irritable mood [ ]  Low energy/fatigue [ ]  Shy

[ ]  Excessive separation difficulties [ ]  Easily frustrated [ ]  Overly anxious/fearful

[ ]  Feelings of worthlessness/low self-esteem [ ]  Withdrawn [ ]  Cries easily

[ ]  Sleep too little [ ]  Sleeping too much [ ]  Excessive need for reassurance

[ ]  Difficulty making decisions [ ]  Temper tantrums [ ]  Rapid mood changes

[ ]  Suicidal thoughts [ ]  Unrealistic worry about future events [ ]  Poor appetite

[ ]  Eats too much

**Behavioral**

[ ]  Engages in impulsive behaviors (acts without thinking)

[ ]  Immature compared to same aged peers [ ]  Engages in physically dangerous activities

[ ]  Often argumentative with adults [ ]  Often actively defiant to adult request/rules

[ ]  Often deliberately does things to annoy others (above age expected behaviors)

[ ]  Aggressive toward others – please indicated peers/adults/both:

[ ]  Lies [ ]  Steals

[ ]  Substance Abuse – indicated drugs/alcohol

[ ]  Explosive temper with minimal provocation

Please explain any of the checked items from within all categories of emotional adjustment.

**Unusual or Atypical Behaviors:**

Does your child display any of the following behaviors? Please mark all that apply.

[ ]  Preoccupation with specific subjects, topics, or objects that is atypical in intensity

[ ]  Eccentric forms of behavior (sometimes referred to as quirky, odd, free-spirited: a person who exhibits eccentric behavior doesn’t seem to be concerned with what others are doing/wearing/saying)

[ ]  Lack of awareness/sensitivity to the needs/feelings of others

[ ]  A need/desire to do things in a specific way or order. Rituals that must be followed

[ ]  Odd mannerisms or ways of moving his/her body. (examples: repetitive foot tapping, rocking, swaying. Can be purposeful or unconscious)

[ ]  Self-injury

[ ]  Difficulty understanding jokes/humor

[ ]  Difficulty adjusting to new surroundings

[ ]  Difficulty adjusting to change in plans/routine

[ ]  Other (please explain)

Please explain any items marked above:

**Social Information:**

How does your child get along with adults in the home?

Hoe does your child get along with other children in the home? (including but not limited to brothers/sisters)

How does your child get along with peers?

What are your child’s behavior/social strengths?

What are your child’s behavior/social areas for growth?

**School Information:**

List, in order of attendance, the schools your child has attended. For children younger than 7, include preschools and/or daycare centers.

 School/Preschool Dates of Attendance

Has your child ever repeated a grade? [ ]  YES [ ]  NO If yes, what grade?

Describe your child’s strengths at school.

Describe your child’s areas for growth at school.

Has your child ever been involved in any of the following?

 Dates/Duration

[ ]  Educational services from a private entity

 Private tutor/Sylvan Learning/etc.

[ ]  Therapy services from a private entity

[ ]  Juvenile Court/Probation

[ ]  Hospitalization

[ ]  First Steps

[ ]  Jumpstart (ISTEP Remediation program)

[ ]  Summer School

[ ]  Other Early Intervention Program

Please explain any items checked:

Other information you believe may be relevant in the evaluation of your child:

**Name of person completing this form:** **Date:**