CHILD EVALUATION FORM

Date: ____________________

Child's Name: ____
(Last) (First) (Middle)

Address: ____

City/State/Zip: ____

Date of Birth: ____Age: ________________

Handedness: R L

Home Phone: _____________________ Mobile Phone Number: _______________________________

Mother's Name: ____

Business Phone: ___________________ Mobile Phone Number: ___________________

Occupation: ____

Father's Name: ____

Business Phone: ___________________ Mobile Phone Number: ___________________

Occupation: ____

Relationship Status: _____________________

Names and ages of siblings and any live-in relationships:

____

____

Business Phone: _______________________________

Email: ____

In case of emergency contact: ____

Referral Source:

Please tick and rate the conditions that apply to your child by placing a 0, 1, 2 or 3 to indicate the level of severity: 0=not being a problem at all, 1=mild, 2=medium, 3=severe. Please include any additional information about the disorders such as age of onset, length of duration, interventions undertaken, that you consider important.

EMOTIONAL:

- ☐ Anxiety 0 1 2 3
- ☐ Depression 0 1 2 3
- ☐ Mood swings 0 1 2 3
- ☐ Fears 0 1 2 3
- ☐ Frustration 0 1 2 3
- ☐ Anger 0 1 2 3
- ☐ Tantrums 0 1 2 3
- ☐ Obsessive worries 0 1 2 3
- ☐ Compulsions 0 1 2 3
- ☐ Phobias 0 1 2 3

SELF-CONCEPT:

How child feels about self ________________

PEERS AND PLAY:

- ☐ Friends 0 1 2 3

SCHOOL:

- ☐ Teacher complaints 0 1 2 3

☐ Problems with other students	0	1	2	3
☐ Homework	0	1	2	3

LANGUAGE AND COGNITIVE SKILLS:

☐ Verbal expression	0	1	2	3
☐ Reading	0	1	2	3
☐ Spelling	0	1	2	3
☐ Writing	0	1	2	3
☐ Math	0	1	2	3
☐ Art	0	1	2	3
☐ Sense of direction	0	1	2	3
☐ Memory	0	1	2	3

EXECUTIVE FUNCTION:

☐ Attention	0	1	2	3
☐ Distractibility	0	1	2	3
☐ Impulsivity	0	1	2	3
☐ Ability to organize time and space	0	1	2	3

MOTOR ACTIVITY:

☐ Over-active or under-active	0	1	2	3
☐ Coordination	0	1	2	3
☐ Accident prone	0	1	2	3
☐ Sense of self in space	0	1	2	3

- ☐ Motor tics 0 1 2 3
- ☐ Vocal tics 0 1 2 3

BEHAVIOR:

- ☐ Uncooperative 0 1 2 3
- ☐ Inflexible 0 1 2 3
- ☐ Unpredictable 0 1 2 3
- ☐ Manipulative 0 1 2 3
- ☐ Insensitive to others 0 1 2 3
- ☐ Oppositional 0 1 2 3
- ☐ Defiant 0 1 2 3
- ☐ Aggressive 0 1 2 3

MORALS AND ETHICS:

- ☐ Lying 0 1 2 3
- ☐ Cheating 0 1 2 3
- ☐ Stealing 0 1 2 3
- ☐ Doesn’t know right from wrong 0 1 2 3
- ☐ No guilt feelings 0 1 2 3

REGULATORY BEHAVIOR:

- ☐ Sleep 0 1 2 3
- ☐ Bedwetting 0 1 2 3
- ☐ Nightmares or night terrors 0 1 2 3
- ☐ Soiling 0 1 2 3

☐	Teeth grinding	0	1	2	3
☐	Eating habits	0	1	2	3
☐	Awareness of appetite	0	1	2	3
☐	Thirst awareness	0	1	2	3
☐	Food sensitivities	0	1	2	3
☐	Food cravings	0	1	2	3
☐	Sugar craving or reaction	0	1	2	3

GENERAL HEALTH:

☐	Frequent illness	0	1	2	3
☐	Headaches	0	1	2	3
☐	Stomachaches	0	1	2	3
☐	Chronic constipation	0	1	2	3
☐	Allergies	0	1	2	3
☐	Asthma	0	1	2	3
☐	Pain	0	1	2	3
☐	Fainting	0	1	2	3
☐	Seizures	0	1	2	3
☐	Hearing problems	0	1	2	3
☐	Vision problems	0	1	2	3
☐	Skin problems	0	1	2	3

PERSONAL HISTORY

Please tick next to relevant data that apply to your child. Please include any additional information about the disorder or historical circumstance such as age

of onset, length of duration, interventions undertaken, that you consider important.

BIRTH AND EARLY CHILDHOOD DEVELOPMENT

Adopted at age: _____

Prenatal stress or injury _______
Prenatal drug exposure _______
Difficult labor _______
Difficult birth _______
Premature or late birth _______

MEDICAL PROBLEMS AFTER BIRTH:

Colic _______
Sleep problems _______
Eating problems _______
Activity level _______
Attachment _______
Emotional development _______
Motor development _______
Language development _______
Chronic ear infections _______
Allergies _______
Asthma _______

SERIOUS MEDICAL EVENTS:

Head injury _______
Accidents _______
High fever _______
Serious illness _______
CNS infection _______
Drug overdose _______
Poisoning _______
Anoxia _______
Stroke _______

PSYCHOLOGICAL TRAUMAS AND STRESSES:

Abuse or neglect _______
Family stress _______
School or job stress _______
Death in family _______
Illness _______

TREATMENT HISTORY

MEDICATIONS:

Medication	For Condition	Dose	Dates

MEDICAL TREATMENT:

Procedure	For Condition	Description	Dates

PSYCHOLOGICAL THERAPY:

Therapy	For Condition	Therapist	Dates

OTHER THERAPY:

Therapy	For Condition	Therapist	Dates

FAMILY HISTORY

Symptom	Yes	No	Relationship
Asthma			
Autoimmune Disorders: I Diabetes, Rheumatoid Arthritis Lupus, MS, Scleroderma, etc.			
Thyroid disorder			
Migraine			
Sleep Problems			
Depression			
Manic-depression			
Anxiety			
Phobias			
Panic Attacks			
Motor or Vocal Tics			
Seizures			
Eating Disorders or Obesity			
Addictions			
Obsessive Compulsive Symptoms			
Speech Problems			
Attention Problems			
Hyperactivity			
Learning Problems			
Conduct Problems or Criminal Behavior			
Autism spectrum			
Schizophrenia			