The Levin Center

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CLIENT INFORMATION

Client's name:_____

Date of birth: _____

Age: _____ Sex: Male Female

Name of Person Completing This Form: _____

Relationship to Child: _____

Today's date: _____

Address: _____

_____

Phone: _____

Source of referral: _____

School name: _____

Year in school: _____

PRESENTING CONCERNS

Briefly explain the main concerns that have led you to seek an evaluation or consultation:

_____

_____

How will you use the results of this evaluation/consultation (i.e., personal use, school, tutor, court, therapist, SAT accommodations)?

_____

_____

FOR OFFICE USE ONLY

DI DATE: _____ TEST 1 DATE: _____ TEST 2 DATE: _____ FB DATE: _____

CONTACT INFORMATION

1. Parent/Guardian: _____

Relationship to child: _____

Parent/Guardian's address (or same as above): _____

Parent/Guardian's phone: _____ (cell) _____ (home) _____ (work)

Parent/Guardian's email address: _____

Occupation: _____

Highest grade of school completed or highest degree received: _____

2. Parent/Guardian: _____

Relationship to child: _____

Parent/Guardian's address (or same as above): _____

Parent/Guardian's phone: _____ (cell) _____ (home) _____ (work)

Parent/Guardian's email address: _____

Occupation: _____

Highest grade of school completed or highest degree received: _____

Preferred Parent/Guardian and method of contact (i.e., Mom Cell): _____

Can we leave phone messages? _____Yes _____No

Can we use email to schedule/remind you of appointments? ____Yes ___ No

Marital status of parents:
____ Married ____ Divorced ____ Separated ____Never Married

If separated or divorced, who has custody of child? Please explain:

_____

Are there stepparents or other adults living in the home? If yes, please provide names and contact information:

_____

Other than parents, who has responsibility for the care and education of the child (i.e., grandparent, nanny)?

_____

List names of brothers and sisters and ages.

Name	Age	Relationship to child	Living at home?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Currently, are there any significant stressors or pressures on the family? If yes, describe below:

_____

_____

FAMILY HISTORY

Please place a checkmark by the problems that describe your child's family history.

	None	Mother	Father	Siblings	Other Relative (aunt, uncle, grandparents)
Hyperactivity/Impulsivity					
Attention problems (ADHD, ADD)					
Learning problems (LD in reading, math, writing)					
Nervousness/anxiety					
Depression					
Bipolar/mania					
Schizophrenia					
Other (please describe):					

Has there been **a history** of any of the following in the **child's** or **family's life**?

Trouble with the law?	☐ No ☐ Yes
Domestic violence?	☐ No ☐ Yes
Concerns about **child's** drug or alcohol use/abuse?	☐ No ☐ Yes
Parent drug or alcohol abuse?	☐ No ☐ Yes
Physical abuse/neglect?	☐ No ☐ Yes
Sexual abuse?	☐ No ☐ Yes
Frequent moving?	☐ No ☐ Yes
Gang involvement?	☐ No ☐ Yes
Suicide attempts/completion?	☐ No ☐ Yes

If yes to any of the above items, please describe impact on this child:

_____

_____

_____

PREGNANCY AND BIRTH HISTORY

Mother's age at this pregnancy: _____ Number of Pregnancy: ____First ___ Second ___ Third ____ Other

Describe any problems during the pregnancy: _____

_____

_____

During the pregnancy did the mother:

Drink Alcohol? ___Yes ___No Smoke? __Yes ___No Use Drugs? ___Yes ___No

Gestational Age at Birth (i.e., number of weeks of pregnancy): _____

Birth Weight: ____ lbs ____ oz

How was the child born? ___Vaginal Delivery ___ Cesarean Section

Did the baby breathe on his/her own right away? ___Yes ___No

Were any delivery complications or birth defects noted? ___Yes ___No
If yes, please describe:

_____

Any problems in the first year of life? If yes, please describe:

_____

_____

DEVELOPMENTAL HISTORY

Motor
At what age did the child: Sit Up: _____ Crawl: _____ Walk:_____

Was the child slow to develop motor skills or awkward in comparison to his/her brothers and sisters?
_____No _____Yes

If yes, please describe:._____

Handedness: ____Right ____ Left ___ Both

Family history of left-handedness? _____No ____Yes
If yes, please list left-handed relatives:_____

Has the child ever had Occupational Therapy (OT) or Physical Therapy (PT)? _____No _____Yes
If yes, please describe reason for concerns and dates of service:

_____

Language
At what age did the child: Speak First Word: _____ Put 2-3 Words Together: _____

Any history of poor sucking, problems chewing, or late drooling? ___No ___Yes
If yes, please describe: _____

Any history of speech delays or problems (i.e., difficult to understand, stuttering)? ___No ___Yes
If yes, please describe:

_____

_____

Has the child ever had Speech-Language Therapy? ___No ___Yes

If yes, please describe reason for therapy and dates of service: _____

_____

Any language other than English spoken in the home? ___No ___Yes
If yes, please describe: _____

Did the child have difficulties learning the alphabet or learning to read? ___No ___Yes
If yes, please describe: _____

Has the child ever lost developmental skills in any area? ___No ___Yes
If yes, please describe: _____

Toileting
At what age was this child toilet-trained? _____

Were there any significant bed-wetting or daytime urine accidents after toilet training? If yes, please explain:

_____

HEALTH HISTORY

Has your child ever had a serious accident or injury? ___No ___Yes
If yes, please describe: _____

Has your child ever been hospitalized or had surgery? _____ No _____ Yes
If yes, please describe: _____

Has your child ever experienced any of the following issues (check all that apply)?

- ☐ Dizziness
- ☐ Frequent headaches
- ☐ Abdominal Pains/Vomiting
- ☐ Concussion/head injury
- ☐ Loss of Consciousness
- ☐ Tics
- ☐ Severe allergic reaction
- ☐ Other
- ☐ Chronic Allergies
- ☐ Chronic ear infections
- ☐ PE Tube placement
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Seizure/epilepsy
- ☐ Asthma

If yes to any of the above, please describe: _____

_____

_____

Explain any health problems your child has experienced other than routine illnesses:

_____

_____

_____

Does your child get regular exercise? _____ No _____ Yes
If yes, please describe (i.e., which activities?):_____

_____

Does your child see a physician regularly? _____No _____Yes

Is vision and hearing testing up to date? _____No _____Yes Wear contacts or glasses? _____ No ____Yes

Does your child **currently** take any medications or **ever taken** medication in the past for extended periods?
____No ____Yes

Medication	When started	For what purpose?	When Stopped

SOCIAL/PSYCHOLOGICAL HISTORY

What are your child's favorite activities and past times?

_____

_____

_____

_____

Has your child ever been seen by a psychologist (private or school)? ____No ____Yes

If yes, please describe (i.e., name of psychologist, reason for visit, dates, and length of services):

_____

_____

Has your child ever been seen by a psychiatrist? ____No ____Yes
If yes, please provide name of psychiatrist, for what purpose, dates, and for how long:

_____

_____

Has your child ever been hospitalized for mental health reasons? ___No ___Yes
If yes, please provide name of facility, for what purpose, dates, and for how long:

_____

_____

Have there been any problems in the following areas (check all that apply)?

☐ Eating Difficulties
☐ Weight loss or gain
☐ Sleep Difficulties
☐ Difficulties Holding a Pencil
☐ Aggression
☐ Anxiety
☐ Short Attention Span
☐ Depressed or Sullen Mood
☐ Impulsivity or Hyperactivity
☐ Memory Forgetfulness
☐ Noncompliance at Home
☐ Noncompliance at School
☐ Quick changes in mood
☐ Self-Injurious Behavior
☐ Bullying
☐ Peer Difficulties
☐ Suicidal Feelings or Actions
☐ Worrying or Nail Biting

Explain any of the items above: _____

_____

_____

Please describe your child's peer relationships and friendships. Note any concerns you have:

_____

_____

EDUCATIONAL/ SCHOOL HISTORY

Name of **current** school or college/university: _____
_____Public _____ Private _____ Home-school _____ Private specialty school

School District: _____
Current grade in school: _____

For all schools attended, please list chronologically each school's name, grades of attendance, and description of any problems noted by teachers/parents.

School Attended	For Grades	Problems Noted	Description of Problem
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

Currently, has parent/guardian or child's teacher reported problems in the following areas (check all that apply):

☐ Reading
☐ Spelling
☐ Arithmetic
☐ Writing
☐ Attention/Concentration
☐ Behavior (e.g., fighting, impulsivity, etc.)
☐ Other: _____
☐ Social Adjustment
☐ Note-taking
☐ Test-taking
☐ Homework Completion
☐ Study Skills

Has your child **ever** received accommodations or special education services at school (currently or in the past)?

☐ No
☐ Yes

Type of current school placement and services received (check all that apply):

☐ Regular classroom ☐ Learning Support ☐ Special Education
☐ Section 504 Plan ☐ IEP ☐ Self-contained classroom
☐ Other: _____
☐ Tutoring (Describe which subject(s):_____)
☐ Don't Know or Not Sure

Type of school placement and services received in past (check all that apply):

☐ Regular classroom ☐ Learning Support ☐ Special Education
☐ Section 504 Plan ☐ IEP ☐ Self-contained classroom
☐ Other: _____
☐ Tutoring (Describe which subject(s):_____)
☐ Don't Know or Not Sure

Please describe all accommodations used over the past year (i.e., extra time, note-taker, laptop, etc.):

_____

_____

Please describe all accommodations used in the past and in which grades (i.e., grades 1-3, grades 4-7):

_____

_____

Any grades repeated or skipped? _____No _____Yes
If yes, please describe: _____

Has the child ever been **suspended** or **expelled** from school?
☐ No ☐ Yes If yes, please provide details (date/grade in school, reason for suspension/expulsion):_____

_____

If available, please provide SAT/ACT scores:

SAT: _____Reading _____ Mathematics _____Writing

ACT:_____ English _____ Mathematics _____ Reading _____ Science _____Composite

If child is in the 10th grade or not taken SAT/ACT yet, please provide PSAT/PLAN scores (if available):

PSAT: _____Reading _____ Mathematics _____Writing

PLAN:_____ English_____ Mathematics _____ Reading _____ Science _____Composite

Please list prior psychoeducational or neuropsychological evaluations (list chronologically). *If available, please bring copies of evaluation with you to your appointment.*

Date	Name/Specialty of Doctor	Place of Evaluation	Diagnosis

CHILD'S STRENGTHS/ADDITIONAL COMMENTS

Please describe your child's strengths and any additional information you consider important:

Please add any additional thoughts, homework papers, reports from teachers or other documentation of the difficulties your child is experiencing.