



Dear Parents:

Your completion of this form will greatly help in understanding your child, adolescent, or young adult (referred to as "client" below). This information is confidential and will not be released without written permission from you; however, there are some exceptions to confidentiality, which are discussed in detail on the Consent Form. This data is useful in understanding the questions to be answered by the evaluation and may be referred to in the written report. If extra space is needed, please feel free to attach additional pages for your comments.

Date: _____

Person(s) filling out this form: Father _____ Mother _____ Other _____

I. IDENTIFYING DATA

Child's Name _____ Sex _____ Age _____

Date of Birth _____ School _____

Current Grade _____

Child lives with _____

at _____

(address, city, state, zip)

(area code & home phone number)

(cell phone number)

(e-mail address)

* In cases of custody agreements, single-parenthood, or legal guardianship being assumed by person(s) other than a biological parent, The Center for Family & Children is required to have documentation of the court-ordered custody agreement with submission of paperwork. Failure to provide this information will delay your appointment.

Referred by _____

List names, as appropriate:

Father _____

Step-father _____

Mother _____

Step-mother _____

How often does the child visit the non-resident parent? _____

Present Occupation of resident parents:

Father (step-father) _____ Business phone _____

Mother (step-mother) _____ Business phone _____

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PURPOSE OF THIS EVALUATION:

What questions would you like answered by this evaluation? _____

This child's strengths include _____

I believe this child's main difficulty to be _____

For whom is the report intended (e.g., present school, future school, physicians, etc.)?

II. DEVELOPMENTAL HISTORY

A. Was this child adopted? _____ If yes, age at time of adoption _____ Has this child been told (s)he was an adopted child? _____

B. Mother's medical history during pregnancy:

This child was which of the total number of pregnancies (1st, 2nd, etc.)? _____

When did prenatal care begin? _____

Was the birth mother treated for any of the following? (Give the approximate month of pregnancy)

1. Convulsions _____

2. Infections _____

a. Virus _____

b. Measles _____

c. Hepatitis _____

d. Toxemia _____

e. Other _____

3. What medications were taken during pregnancy? _____

When? _____

4. Were the following factors present during pregnancy?

a. Pelvic irradiation _____

b. Unusual nutritional factors _____

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- c. Uterine abnormalities _____
- d. RH incompatibility _____
- e. Bleeding _____ When? _____ Duration _____
- f. Accidents during pregnancy _____
- g. Emotional pressures during pregnancy (describe briefly) _____

III. OBSTETRICAL HISTORY FOR THIS CHILD

Where was child born _____

Length of pregnancy _____

Length of labor (approximate hours) _____

Spontaneous? _____ Induced? _____

Delivery:

- a. Was delivery rapid? (how quickly?) _____
- b. Position normal? _____
- c. Forceps assisted? _____
- d. By planned or unplanned Cesarean section? _____
- e. If placed in incubator, for how long? _____
- f. Weight at birth _____ lbs., _____ oz. Color at birth _____

Child's first year:

- a. Active _____ Passive _____ Contented _____ Fretful _____
 Was the baby breast-fed? _____ How long? _____
- b. Colic? _____ Describe _____
- c. Volatile vomiting? _____
- d. Digestive problems? _____
- e. Allergies? _____
- f. Was there difficulty in establishing sleep patterns? _____
- g. Were medications prescribed in the first year? _____
 If so, what medication (or type) _____ Why given? _____

IV. DEVELOPMENTAL HISTORY OF CHILD

Behavior	Age Accomplished	Comments About the Achievement
held head erect		
rolled from back to stomach		
first tooth		
sat unsupported		
crept or crawled/how long		
stood alone		
walk unattended		
drank from a cup		
weaned		
ate alone with spoon		
first words spoken		
talked in short sentences		
talked clearly enough that strangers understood		
became toilet trained		(easily/difficult)
learned to skip		
began bicycle riding with training wheels		
began bicycle riding without training wheels		

V. MEDICAL HISTORY OF CHILD

If the child has had any of the following, give approximate age if actual age is not remembered.

Mumps _____ Measles _____ Chicken Pox _____ Meningitis _____
 Frequent headaches _____ Hearing problems _____ Stomach upsets _____

Frequent colds _____ Whooping Cough _____ Hay Fever _____
Sore throats _____ Cerebral Palsy _____ Ear infections _____
High fevers: Age _____ Cause _____ How high _____
How long _____
Allergies to _____
Comments _____

Please describe any other medical conditions _____

Describe any serious accidents this child has had _____

Age at time of accident _____ Actions taken _____

Treatment given _____

Hospitalizations (state age, duration and reason) _____

This child was last seen by Dr. _____ Date _____
(Please print first and last names)

The physical examination revealed _____

Is this child taking any medication? _____ What? _____

Dosage _____ Prescribed by _____ How long _____

Any other medications taken in the last twelve months? _____

Hearing has/has not been checked:
at school _____; in doctor's office _____; by an Audiologist _____ Date _____

Results: adequate/inadequate. If inadequate, please explain _____

Vision has/has not been checked:

at school _____; in doctor's office _____; by an ophthalmologist/optometrist _____

Date _____

Results: adequate/inadequate. If inadequate, please explain _____

Is this child on a special diet? _____ Restrictions _____

VI. FAMILY HISTORY

Present health of immediate family members _____

Additional comments _____

List by name the members of this child's family. Please include parents, step-parents, full, half, and step-siblings.

Name of Family Member	Relationship to This Child	Age	Highest Year of School Completed	Name Any Grade Repeated	Reading, Writing, Math or Speech/ Language Problems? If so, which and when?

Please note a history of the following illnesses/difficulties (cousins, aunts, uncles, and grandparents, as well as immediate family members, are to be included):

Illness/Difficulty	Check if Yes	When Occurred	Relationship to Child (e.g., maternal aunt)
Convulsive Seizures			
Autism Spectrum Disorders			
Mental Retardation			
Drug Addiction			
Criminal Record			
Depression			
Bipolar Disorder			
Psychotic Disorder/ Schizophrenia			
Anxiety Disorders			
Articulation Problems			
Deafness			
Reading, Writing, Spelling Problems (note which)			
Mathematics Difficulty			
Hyperactivity			
Attention Problems			

VII. SCHOOL HISTORY

Daycare program? _____ from age _____ to _____

Preschool program? _____ from age _____ to _____

Name and location of preschool program(s): _____

List the names of schools attended beginning with kindergarten:

School Name	Child's Age	Grade	City/State	School System (public/private)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Was entry into first grade delayed by attending Kindergarten twice or a pre-first grade? _____

Current School Data:

a. The child's best subject(s) is/are _____

b. Grade history (general) _____

c. Please list your child's most recent grades _____

d. Does your child finish his/her work in class? Yes _____ No _____

e. Does your child have trouble paying attention? Yes _____ No _____

f. Does your child have trouble staying in his/her seat when asked? Yes _____ No _____

g. Does your child have difficulty working independently? Yes _____ No _____

h. Has your child had (or having) special help at school? Yes _____ No _____

If so, what type (e.g., tutoring, speech therapy, resource room) and when? Please describe.

Homework: Done easily? _____ With difficulty? _____

Needs help with (describe) _____

Source of help: At Home _____ At School _____

Studies: When _____ Where _____

How long? _____

Puts off studying until last minute _____

Does your child like school? _____ Comments _____

What does the teacher think the problem is? _____

What does the teacher think about the child's behavior? (e.g., general attitude, response when corrected, relationship with classmates, etc.) _____

VIII. BEHAVIOR

This child has had or is still having problems with which of the following:

	What Age(s)	How Often
Bullying	_____	_____
Shyness	_____	_____
Withdrawn from peers	_____	_____
Aggressive behaviors	_____	_____
Appears anxious	_____	_____

This child has had or is still having problems with which of the following:

	What Age(s)	How Often
Fear of darkness	_____	_____
Restlessness	_____	_____
Daydreaming	_____	_____
Truancy	_____	_____
Fighting	_____	_____
Temper tantrums	_____	_____

Resenting discipline _____
Bad dreams _____
Other (please describe) _____

Has this child ever had contact with the police or juvenile authorities? If so, please explain.

Please describe any unusual behavior patterns your child possesses (positive or negative).

What activities does the family do together? _____

Describe how this child gets along with:

Father _____

Mother _____

Brothers _____

Sisters _____

Step family members in home _____

Others in home _____

Comments _____

This child will talk more freely with (mother, father, sister, brother, other; give relationship)

This child seems to get most upset when _____

This child seems happiest when _____

IX. RECREATION AND INTERESTS

This child has (many, average, few, no) friends.

In recreational activities, this child most often prefers the company of others (younger, older, his/her own age).

If he/she could, he/she would like to have (many, few) friends; do things (alone, with just one friend, in a group).

This child likes best to associate with (boys, girls, both the same).

This child seems to enjoy most those games that are (rough, noisy, quiet; require a great deal of make-believe; require little physical activity; have definite rules).

This child, when losing a game, usually (loses his/her temper, keeps right on playing, works even harder, seems to "give up," blames someone or something for the loss, gets discouraged and wants to quit).

This child likes best to socialize (at home, at someone else's house).

This child likes best to "make rules" and decide how things will go or have someone else make the decisions.

This child (likes, dislikes) close attention or supervision.

What does she/he like to do for recreation? _____

This child takes part in which of the following activities outside of home or school:

Scouts _____ YMCA _____ Clubs _____ Youth Groups _____ Other _____

Please describe any unusual behavior (positive or negative) you have observed at these activities:

What plans do you have for changes in such areas as family, school, social, medical, etc., that have not been mentioned elsewhere in this questionnaire?

X. OTHER SPECIALISTS CONSULTED

Name _____ Date _____

Agency _____ City _____

Their findings/recommendations _____

**Please send copies of all test/evaluation reports,
including Special Education paperwork**

Any additional information you feel will be helpful to us may be written below or on a separate sheet.
