

JEWISH FAMILY & CAREER SERVICES

Child's Name _____ Date _____
Birthdate _____ Sex _____ Chronological Age _____
Grade Placement _____ Evaluation Date _____
School & County(even if private) _____
Head or Principal of School _____
Lead Teacher _____
Referring Person _____

May we send a written thank you to them? Yes _____ No _____

Phone Number(s) of referring person: _____

We apologize for the length of this form and appreciate your taking the time to complete it. All information is confidential and will not be released without your written permission.

Identifying Information

Parent(s)/Guardian(s) _____

Address _____
Number, Street City County State Zip

Father's Name _____ **Year of Birth** _____

Education _____ Occupation _____

Address _____

Email Address _____ SSN: _____

Telephone: H _____ Business _____ Cell _____

Mother's Name _____

Education _____ Occupation _____

Address _____

Email Address _____

Telephone: H _____ Business _____ Cell _____

Referral Information

Who advised that the child be evaluated? _____

For what reason? _____

Relationship of referring person _____

Are any other professionals in contact with the child now or before this evaluation? Yes _____ No _____

If so, who? _____

Date(s) when seen _____

Family Physician _____ Telephone _____

Background Information

Do both parents agree this evaluation is necessary? Yes _____ No _____

Please explain _____

Main concern/chief complaint/reason for requesting this evaluation: _____

When was the problem first observed and by whom? _____

What was done at that time? _____

What behavior(s) did/do you observe to make you suspect a problem? _____

Is the problem observed at home? _____ at school? _____ with other children? _____

What has your child's teacher told you? _____

What is the school's reaction to this evaluation? _____

Pregnancy and Birth History

Was your child adopted? Yes _____ No _____ At what age? _____

What were you told about the pregnancy and birth? _____

Number of pregnancies: _____ What pregnancy was this child? _____

Mother's age at beginning of this pregnancy _____ Father's age _____

Would you consider the pregnancy with this child as a typical pregnancy to you? Yes _____ No _____

If not, how was it different? _____

Have you ever had a miscarriage? Yes _____ No _____ If so, which pregnancy
and what month? _____

How many months was this pregnancy? _____

How long was the labor? _____

Family History Information

Does your child interact appropriately with:

Family Members? _____

Other Children? _____

Teachers/Other Adults? _____

Describe any family problems related to this child: _____

List other immediate family members who have learning/focusing problems: _____

Describe the nature of the problem _____

Treatment _____

Have there been any problems in the mother's or father's family with?: (Please check those that apply.)

Speech _____ Academics _____ Cancer _____

Language _____ Psychological _____ Drug Addiction _____

Hearing _____ Epilepsy _____ Alcoholism _____

Learning _____ Neurological _____ Mental Retardation _____

Physical _____ Heart Disease _____ High Blood Pressure _____

Diabetes _____ Other: _____

Describe the relationship and problem: _____

Childhood Illness History

Symptom Severity

<u>Illnesses</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>	<u>Age/Treatment</u>
<u>Measles(type)</u>	_____	_____	_____	_____
<u>Whooping cough</u>	_____	_____	_____	_____
<u>Scarlet Fever</u>	_____	_____	_____	_____
<u>Encephalitis</u>	_____	_____	_____	_____
<u>Meningitis</u>	_____	_____	_____	_____
<u>Mumps</u>	_____	_____	_____	_____
<u>Polio</u>	_____	_____	_____	_____
<u>Chicken Pox</u>	_____	_____	_____	_____
<u>Infections</u>	_____	_____	_____	_____
<u>Accidents</u>	_____	_____	_____	_____

Other(specify) _____

Complications _____

Has this child had prolonged high fevers? Yes _____ No _____

Temperature in Degrees _____ How long at this temp? _____

Has the child had seizures? Yes _____ No _____

If so, describe _____

Treatment, if any _____

Blended Family Information

Step Father's Name _____ **Year of birth** _____

Education _____ Occupation _____

Address _____
Number/Street _____ City _____ County _____ State _____ Zip _____

Email Address _____

Telephone: Home _____ Business _____ Cell _____

Step Mother's Name _____ **Year of birth** _____

Education _____ Occupation _____

Address _____
Number/Street _____ City _____ County _____ State _____ Zip _____

Email Address _____

Telephone: Home _____ Business _____ Cell _____

Other Children (Please include relationship if step or half-sibling):

<u>Name</u>	<u>Birth date</u>	<u>Sex</u>	<u>Grade</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date of marriage of parents: _____

Date of divorce of parents: _____

Date of remarriages of parents: _____

(Please list dates of any subsequent divorces or marriages as well)

Living Together _____ Widowed _____ Date: _____

Relationship of others living in the home: _____ Length of Stay _____

Health Issues

Has the child had any glandular disturbances? Yes _____ No _____

If so, describe _____

Treatment, if any _____

Is your child allergic to anything: Yes _____ No _____

If so, to what _____

Treatment, if any _____

Describe illnesses concerning ears, nose and throat(tonsillitis, ear infections, draining ears, hay fever, etc.)

Describe any problems of the chest, heart, lungs(chronic cough, pneumonia, heart condition, asthma, etc.)

Has the child had any kidney problems (infections, blood in the urine, etc) _____

Does the child take any drugs or medications routinely? Yes _____ No _____

If so, name and purpose _____

Social Bearing

How is the child usually disciplined? _____

By Whom? _____

What is most effective? _____

What is least effective? _____

Does the child have any routine chores or responsibilities? Yes _____ No _____

If so, what are they? _____

How often are they to be performed? _____ Are responsibilities performed? _____

Does the child receive an allowance? Yes _____ No _____ How much? _____

Attention Issues

Do you consider your child to be overactive? _____ Distractable? _____

Dis-inhibited (internally distracted) _____

Does your child have difficulty persisting at tasks? _____

Focusing attention? _____

Sustaining attention? _____

Do others (teachers, friends, pediatrician, family members) concur with your observations regarding attention? Yes _____ No _____

If not elaborate _____

How much time does your child spend each day watching TV? _____

What TV programs does he/she particularly like? _____

Do you have any particular rules in your family regarding TV? _____

If so, describe _____

Social/Affective Development

At what age did this baby smile at parents? _____ At strangers? _____

Did this baby like attention? _____ Want to be left alone? _____ Have "blank" spells? _____

Tear up toys more than expected? _____ Rock? _____ Bump or bang head? _____

Was the baby affectionate? _____ Friendly? _____

How does the child react to the following:

New situations: _____

Being separated from parents _____

Danger _____

Right/Wrong (Discipline?) _____

Describe any problem(s) your child has or had in understanding what is said. Include any changes or special efforts you might have made or continue to make to assure understanding.

Does he/she understand and use gestures meaningfully? Yes _____ No _____

How does he/she make wants known at the present time? _____

Describe any problem(s) your child has had talking. _____

What was your reaction?

Is the child's speech understandable to you? Yes _____ No _____

Is the child's speech understandable to people outside the family? Yes _____ No _____

Has he/she ever used more language than he she does now? Yes _____ No _____

If so, explain and indicated when and why you think the change occurred.

Does he/she relate experiences/events? If so, how? _____

Does he/she frequently use gestures when relating experiences? Yes _____ No _____

How would you compare this child with your others, or other children, in his/her ability to relate events?

Major Development

At what age did your child do the following?:

Sit without support _____

Crawl _____

Stand without support _____

Feed self with hands _____

Feed self with utensils _____

Toilet training:

Bladder-Day Time _____

Bowels- Day Time _____

Walk _____

Run _____

Hop _____

Skip _____

Bladder-Night Time _____

Bowels-Night Time _____

Does your child have particular difficulty with puzzles? _____

With drawing? _____

Writing? _____

Surgeries/Operations

Has the child ever had surgery? _____ Ever been hospitalized? _____

Age of child and each length of hospitalization _____

Reactions _____

Sight Information

Has your child ever had his/her eyes examined? Yes _____ No _____

If so, when _____ By whom? _____

Results? Near _____ Far _____ Tracking _____ Scanning _____

If corrected, what is vision? _____

Has he/she received visual training? Yes _____ No _____

If yes, when _____ Why? _____

How Long? _____ How often? _____

Does he/she tilt their head to look at things? Yes _____ No _____

Does he/she hold pictures or objects close while looking? Yes _____ No _____

Does he/she squint? Yes _____ No _____

Do your child's eyes tire easily? Yes _____ No _____

If so, describe _____

Hearing Information

Has the child ever had his/her hearing tested? Yes _____ No _____

If so, when _____ By whom _____

Acuity _____ Discrimination _____

Results of exam _____

Did you ever suspect a hearing problem? Yes _____ No _____ If so, what age? _____

Why _____

What was done? _____

If you suspected a problem, describe the types of sound to which he/she responded or now responds, such as a telephone, airplane, car door, voices, etc. _____

Has fluid ever been noted in the child's ears? Yes _____ No _____ If so at what age(s)? _____

Were tubes placed in the ears? _____ when _____

Were medications given? _____ Length of time? _____

Does he/she consistently turn one ear to a speaker? Yes _____ No _____ If yes, which ear? _____

Is his/her response to sound consistent? _____

Does your child cover his/her ears in response to sound? Yes _____ No _____

Social Behaviors

Does your child make friends easily? Yes _____ No _____

Does your child understand cause-and-effect situations? Yes _____ No _____

Does your child interpret the social behaviors of others accurately and appropriately? In other words, do they understand why others act the way they do? _____

How does your child react to other children? _____

How do other children react to your child? _____

Describe his/her closest friend or children with whom he or she prefers to play _____

Does your child respond appropriately to the feedback/reactions of others about his/her actions? _____

Does your child prefer to play: alone? _____ with one other child? _____ in a small group? _____

Or in a large group _____

With what age children does your child usually play? _____

With what age children does your child prefer to play? _____

When playing alone, how does your child entertain him/herself? _____

Does your child prefer to have you suggest things to do? _____

Affective Reactions

What are your child's mood shifts like? _____

How does your child react to:

Praise? _____ Constructive Criticism? _____

Teachers? _____ Going to School? _____

Failure? _____

How does your child show feelings of:

Anger? _____ Disappointment? _____

Happiness? _____ Surprise? _____

Excitement? _____

What does your child feel about himself or herself/self-concept? _____

Would you describe your child as: Anxious? _____ Tense? _____ Easy-going? _____

Not as "aware as expected? _____

Does your child understand the humor: directed toward them? _____

In cartoon and comics? _____ Stories? _____ Jokes? _____

Make a statement regarding your child's temperament: _____

General Behavior

In general, is your child's behavior consistent from day to day? _____

Describe types of activities he/she enjoys: _____

If your child plays sports; which sports and to what extent does he/she participate? _____

Is the child aware of accident-producing situations? Yes _____ No _____ If not, describe _____

Can your child: manage his/her own money? _____; identify coins? _____; make change? _____

Can your child tell time? _____ If so, how well? _____

Does your child like to read? _____; Be read to? _____ Daily how much time is spent on these: _____

For older children, were the following learned as expected: Telling time _____; Math _____

Money Management _____; Writing _____ Reading _____; Spelling _____

General Behavior Continued

Indicate how often the following occur by marking N=never; S=sometimes; F=frequently on the left column.

List, on the right, possible causes/situations that precipitate the behavior and what follows that behavior.

_____	Sleepiness	_____
_____	Bedwetting	_____
_____	Refusal to obey	_____
_____	Thumbsucking	_____
_____	Strong Fears	_____
_____	Destructiveness	_____
_____	Shyness	_____
_____	Fighting	_____
_____	Strong hates	_____
_____	Temper tantrums	_____
_____	Complaining	_____

How do you react to these problems? _____

If you have/know other children, how do you compare this child with those children in regards to the above behaviors they exhibit? _____

Education History

	<u>Name of School</u>	<u>Type</u>	<u>Age Attended</u>
Nursery	_____	_____	_____
Kindergarten	_____	_____	_____
Elementary	_____	_____	_____
Other Schools	_____	_____	_____

If your child had difficulty adjusting to any school year, please explain: _____

At any time, has a teacher or school indicated a problem? _____ If yes, explain _____

Has your child received special tutoring? _____ If so, content/subject? _____

Reason? _____; Where? _____ Age? _____

Hours/day or week? _____ Year(s)? _____

Has your child repeated a grade? _____ Which one? _____

Best Subjects _____

Poorest Subjects _____

Organization skill for homework? _____

Does your child require help in completing assignments: _____

How many hours are spent on homework? _____

How would you compare this child with others in their performance? _____

How does your child feel about school? _____

Education History Continued

Please List grades earned on last report card.

<u>Subject</u>	<u>Grade</u>	<u>Comments</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Information for this form given by: _____

Relationship to child _____ Date _____

Phone contacts: Home: _____ Cell _____