Professional Psychology Associates, P.C.

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Identifying Information

Child's Name: ____Child's Date of Birth: ____________ Age:____

Current Address: _______________________________________ How long at this address?: ________________

Informant Name: ______________________________________ Relationship to child: _____________________

Home Phone:________________________________ Work/Cell Phone:___________________________________

Child's School/School Address:____

School Phone: ________________________ Teacher: ___________________________ Grade:_______________

What language(s) does the child speak?:____________What is the primary language spoken at home?: __________

If the child's first language is not English, at what age did they begin to learn English? ________

Caretaker Information

Child's Biological Father:________________________ Occupation:___________________ Yrs of education_____

Father's Home Phone:_________________________ Cell: _______________________

Child's Biological Mother:________________________ Occupation:___________________Yrs of education_____

Mother's Home Phone:_________________________ Cell: _______________________

Child's Legal Guardian (if not biological parent):______________________Occupation:___________________

Yrs of education_____ Guardian's Home Phone:________________________ Cell: _______________________

Are the child's biological parents married or separated? □ married □ separated □divorced □ never married
If separated, how old was your child at that time?________

If separated, who has legal custody of the child at this time? □ mother □ father □ other _________________

Are there other adults who have a significant part in raising your child? □Yes □No
If so, please indicate name & relationship (step-parent, grandparent, boy/girlfriend, etc.) _____________________

____

Have there been any significant changes in the home over the last few years? (Such as new marriages, deaths, births, address changes, family separations/divorce, parent dating, parent job change, money problems, etc)

____

____

Presently, who does the child live with? Name all persons in home(s) (including non-family members) and their relationship to the child:

____

____

____

Please list all locations (city, state) that your child has lived:
1. Birthplace ____Moved at age/grade ________________
2. ____Moved at age/grade ________________
3. ____Moved at age/grade ________________
4. ____Moved at age/grade ________________

Is there a history of physical violence and/or emotional/verbal abuse between caregivers/other individuals in the child's home?

Explain:____

____

Is there a history of divorce, affairs, or ongoing relationship issues between caregivers/other individuals in the child's home?

Explain:____

____

Behavioral Concerns

Please briefly describe the problem(s) that your child is presently experiencing:

____

____

____

____

When did the problem begin? ____

When did you first notice a change in your child's behavior?___________________________________

____

Who referred you to seek psychological services at PPA?_______________________________________

What do you think has caused the difficulties your child is experiencing?__________________________

____

What part of your child's behavior would you most like to see change?____

____

____

What things does your child do well? (list strengths e.g. bright, funny, subjects enjoyed in school, hobbies, etc.)

____

____

What stratagies have you used to manage difficult behaviors?____

____

____

Pregnancy & Birth Information

Is child your: □ biological child □ adopted child □ foster child □ other: _________________________

Mother's age at birth? _________ Did mother receive routine medical prenatal care? □Yes □ No

Please specify any medications used during pregnancy and the reason used:____________________________________

____

Pregnancy lasted _______________weeks / months Child's birth weight: ______pounds _____ounces

APGAR score …at 1 minute_____ …at 5 minutes_____ □ Unsure / Don't know

Did child go home from the hospital at the same time as the mother? □Yes □ No

If No, explain why:____

____

Please check the conditions below that describe the health of the mother during pregnancy:
□ No Complications
□ Blackouts
□ Falls
□ Physical Injury
□ Excessive Bleeding
□ Hypertension
□ Diabetes
□ Excessive Emotional Stress
□ Toxemia
□ Alcohol/drug use: prior to OR during the pregnancy (circle all that apply)
□ Use of Tobacco: prior to OR during the pregnancy (circle all that apply)
□ Exposure to toxic fumes/chemicals/metals

Please check the conditions below that describe the child's delivery:
□ Normal
□ Induced Labor (If so, why?)____
□ C-Section
□ Breech birth
□ Unusually long labor (>12 hrs)
□ Premature # of weeks____________
□ Overdue # of weeks_____________
□ Other Problem (Specify)____

Please check the conditions below that describe the child's health at birth:
□ Normal / No problems
□ Lack of Oxygen
□ Breathing Problem
□ Birth Injury/Defect: ____
□ Jaundice
□ Drug or Alcohol withdrawal
□ Low birth weight
□ Required incubation
□ Newborn ICU # of days _________
□ Other Problem (Specify)____

____

Development

Please indicate the age range when your child performed the following milestones:

Milestone	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years
Sat up without help							
Crawled							
Walked alone							
Walked up stairs							
Spoke first words							
Spoke short phrases							
Spoke sentences							
Fully bladder trained							
Fully bowel trained							
Stayed dry all night							

Behavior in Infancy

During your child's first few years of life, were any of these problems present to a significant degree?

□ Did not enjoy cuddling
□ Was not easily calmed by being held or stroked
□ Difficult to comfort
□ Colicky
□ Problems Feeding
□ Excessive irritability
□ Diminished sleep/poor sleep patterns
□ Difficult nursing
□ Poor eye contact/did not turn towards caregivers
□ Did not respond to name or speech of caregivers
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□ Fascination with certain objects
□ Constantly into everything
□ Frequent head banging
* If checked any above, please describe:____

Temperament

Activity Level – How active has your child been from an early age?

____

____

Distractibility – How well was your child able to maintain focus or concentration, or pay attention to tasks?

____

____

Adaptability - How well was your child able to deal with transition, change, or when denied his/her own way?

____

____

Approach/Withdrawal – How well was your child able to respond to new things (i.e., new places, people, food, etc.)?

____

____

Intensity – Whether happy/unhappy, how strong were your child's feelings exhibited? Were others made aware of when your child was upset, angry, disappointed, etc.?

____

____

Mood – What was your child's basic mood? Did he/she exhibit frequent or rapid changes in mood or temperament?

____

____

Regularity – How predictable was your child's patterns of activity level, sleep, appetite, etc.?

____

____

Does your child have more difficulty than other children his/her age…

- □ Sitting still at meal time
- □ Paying attention when read to
- □ Throwing a ball
- □ Catching a ball
- □ Buttoning & Zipping
- □ Holding crayon or pencil
- □ Accidentally dropping things
- □ Staying focused on TV movies, or videogames
- □ Waiting for turn at play
- □ Knowing left and right
- □ Acting without thinking
- □ Dressing self
- □ Tying shoe laces
- □ Accidentally knocking things over

Child's Health Information

Describe the **current** state of your child's current health: □ Excellent □ Good □ Fair □ Poor

Is your child currently taking any medication? □Yes □ No
If yes, please list medications, dosages, and uses:____

____

____

Has your child had any of the following?	Describe and give details, dates and/or age of onset
□ Serious Illnesses	
□ Head Injuries	
□ Seizures or convulsions	
□ Surgery/Hospitalization	
□ History of Ear Infections	
□ Allergies and/or Asthma	
□ Vision Problems	
□ Hearing Problems	
□ Frequent Nightmares and/or Bedwetting	
□ Concussion and/or Loss of Consciousness	
□ High fever (greater than 103 degrees)	
□ Abnormal Urination	
□ Broken bones	
□ Other health problems	

Is there a **family history** for the following problems?	**Biological** family member with the history… (parent, sister/brother, aunt/uncle, grandparent, 1st cousin, etc)
□ Learning Difficulties (reading, math, writing, spelling, etc.)	
□ Speech or Language problem (articulation, stuttering etc.)	
□ Developmental Disorder (such as Autism, Aspergers, etc.)	
□ Emotional Problems (depression, anxiety, mood swings, etc.)	
□ Mental Retardation	
□ School Failure (failing grades, dropout, etc.)	
□ Drug or Alcohol Addiction	

Has your child ever been identified as having a disability? □Yes □ No
If so, by whom, what age, & what disability?____

____

____

Mental Health History

Has your child ever received psychological counseling and/or psychometric/psychoeducational testing? □Yes □ No
If "yes," by whom (professional/agency), diagnosis (if applicable) and when:______________________

____

____

Please indicate any incidents of sexual, physical, or emotional abuse (include age at time of incident(s):__________

____

____

____

Please describe any incidents of trauma (e.g. death of a parent/sibling, near death experience/severe injury, kidnapping, exposure to violence/pornography etc.)____________________________________

____

____

____

Is there a history of behavioral health issues in the child's **biological** family? (e.g., depression, anxiety, bipolar, schizophrenia, substance abuse, etc.) □Yes □ No
If yes, please explain:____

____

____

Differential Behaviors

Please check below **all** behaviors or characteristics that fit your child over the **past year**:

□ Destructive behavior
□ Frustrated easily
□ Is affectionate with family and friends
□ Responds well to authority figures
□ Boundless energy and poor judgment
□ Withdrawn and/or sullen
□ Cruelty to animals
□ Disorganized, loses things often
□ Shows sudden outburst of physical aggression
□ Has difficulty playing quietly
□ Requires a lot of parent attention
□ Fidgets or squirms in seat
□ Appears to daydream or "zone out" often
□ Nervous habits (nail biting, hair twirling, etc.)
□ Appears depressed & unhappy much of the time
□ Explosive temperament
□ Frequently complains about aches and pains
□ Appears to have low self-esteem
□ Prefers to be alone (or considers self "a loner")
□ Starts fires
□ Lacks motivation
□ Steals or lies
□ Becomes upset with change
□ Fearfulness
□ Frequent peer and/or family conflicts
□ Does not appear to listen to what is being said
□ Always worrying about something
□ Shifts from one activity to another
□ Other____

Home Behaviors

How would you describe your child's personality at home?

____

____

How does your child get along with brothers/sisters?

____

____

Which adult would your child prefer to talk with about a problem?

____

____

Who is the family member that your child feels closest?

____

____

Who is primarily responsible for discipline at home?

____

____

What is the most effective way to deal with your child's behavior problems at home? (spanking, talking, positive reinforcement, time-out, grounding, etc.)

____

____

What discipline strategies are used at home?

____

____

How does your child respond to discipline?

____

____

List any responsibilities your child has at home:

____

____

Does your child do these regularly? □Yes □ No Does your child need frequent reminders? □Yes □ No

Indicate child's… Bed time? ____:____PM Wake time? ____:____ AM
Does child sleep well? _____________

How much time does your child typically spend on electronic media?
Watching TV: _____hrs/day; Playing video/computer games: _____hrs/day; Other________________:
_____hrs/day

Have any family members expressed concerns about your child's behavior? □ Yes □ No

____

____

Social Behavior

How would you describe your child's peer relationships and choice of friends? (i.e. How many friends? What age/genders? Is child shy, outgoing, a leader, a follower, etc? Does child associate w/ scholars or troublemakers?)

____

____

____

How does your child interact with children in the neighborhood?____

____

Educational History

How does your child feel about school?____

____

____

How motivated do you feel your child is to learn?____

____

____

About how much time does your child spend on homework each night?___________________________

____

____

How much of a struggle is homework?____

____

____

How did your child respond to their first day of school?_____________________________________

____

Has your child ever repeated a grade? □ Yes □ No
If yes, explain:____

Does your child receive special school services (IEP, 504 plan, Gifted/Talented)?□ Yes □ No
If yes, which program and when services begin?

____

____

Below, please list schools attended and describe your child's academic and/or behavioral performance (Average GPA, if applicable):

Preschool / Daycare____

____
____
____
____

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ElementarySchool____
____
____
____
____

Middle School____
____
____
____

HighSchool____
____
____
____

Has your child ever been suspended or expelled from school? ___________________
Explain____

____

Please indicate any other concerns in the space below (attach additional pages if necessary):

Respondent:____ Date:______________________________

Completed forms may be returned via fax or mail.