Psychoeducational Evaluation

Parent/Guardian Information

PLEASE COMPLETE & RETURN BY YOUR FIRST APPOINTMENT

Child's Full Name: _____Today's Date: _____

Birthdate: _____ Sex:_____ Age: _____ Grade: _____ School: _____
(Month/Day/Year)

Primary Phone: _____ Receive Texts? ☐ Yes ☐ No

Person's relationship to child completing form:
☐ Mother ☐ Father ☐ Other - Please Specify: _____

Is the person completing this form the child's current legal guardian? ☐ Yes ☐ No

Which, if any, applies to this child? ☐ Adopted: When _____ ☐ Foster Care: Duration _____

Child primarily resides with: ☐ Mother ☐ Father ☐ Foster Family
☐ Guardian (Please specify: _____) ☐ Relative (Please specify :_____)

Part 1: Family Information

Parent/Guardian (1): ☐ Male ☐ Female

Name: _____ Age: _____ Occupation: _____

Contact with Child: ☐ Lives with ☐ Has Visitation: How Often _____ ☐ No Contact*

Parent/Guardian (2): ☐ Male ☐ Female

Name: _____ Age: _____ Occupation: _____

Contact with Child: ☐ Lives with ☐ Has Visitation: How Often _____ ☐ No Contact*

**If biological parent has no contact with the child, please explain*: _____

_____

List all people living in the household (siblings, grandparents, cousins, roommates, etc.)

Name	Age	Relationship to Child

Please complete this section ONLY if the student is being referred for an <u>ADHD</u> evaluation or other <u>behavior</u> evaluation (such as Autism, Anxiety, Depression, etc.)

Primary concerns from parent/guardian:_____

_____

_____

Age of onset of symptoms:_____Duration of problem behavior:_____

Frequency that behavior is a concern:___daily / 1-3 times a week / weekly / monthly/other:_____

Situations that worsen behavior:_____

_____

Situations that improve behavior:_____

_____

Previous treatment and results:_____

_____

Sleep Habits:

Age began sleeping through the night: _____ Current bedtime: __:___Current wake up time: __:___

Any changes in sleep in the past 6 months? _____ (if yes please explain): _____

Where does child sleep: _____ _____

What electronics are in the bedroom? _____

Please check if your child experiences any of the following: __night waking ____nightmares/night terrors __sleepwalking __restless sleep __difficulty falling asleep ____apnea ____daytime sleepiness

<u>Part 2: Developmental Information</u>

Were there any unusual prenatal conditions/difficulties at birth associated with this child? ☐No ☐Yes

If **yes**, please explain:

_____

_____

Did this child leave the hospital at the same time as the mother? No☐ Yes☐

If **no**, please explain:

_____

_____

Was this child exposed to any drugs or alcohol, including cigarettes, during pregnancy? ☐ No ☐ Yes

If **yes**, please explain:

_____

_____

Part 3: Medical History

List any medications below:

Medication	Dosage	Purpose	Prescribing Physician	Duration
Example: Claritin	*10 mg*	*Seasonal Allergies*	*Dr. Johnson*	*2 years 3 months*

Please check all that have been *diagnosed by a professional*:

	✓	Age of Onset and/or Occurrence	Diagnosed by			✓	Age of Onset and/or Occurrence	Diagnosed by
High Fever (103 or above)					Frequent Headaches or Migraines			
Allergies					Depression			
Ear Aches					Major Operations (Type of Surgery)			
Hearing Problems					Epilepsy/Seizures			
Vision Problems					Orthopedic Impairment			
Autism					Neurological Problems			
Speech/Language Difficulties					Cerebral Palsy			
ADHD					Head/Brain Injury			
Bipolar Disorder					Loss of Consciousness			
Intellectual Disability					Birth Defects			
Sleep Disorders					Diabetes			
Oppositional Defiant Disorder					Other:			
Anxiety					Other:			

Comments regarding medical history:_____

_____

_____

_____

Part 4: Education

Please describe this child's **strengths** at home and at school: _____

_____

_____

_____

Please describe this child's **weaknesses** at home and at school: _____

_____

_____

_____

Describe any concerns you have about your child's physical, social, emotional, behavioral, developmental, communication skills, or ability to learn:

_____

_____

_____

_____

Part 5: Additional Information

Prior or Current Services

	REASON	DATES	NAME OF SERVICE PROVIDER/COMPANY
Counseling/Therapy			
IEP or 504 Plan			
Behavior Evaluation			
Other:			
Other:			

Please explain any additional information regarding this child (adoption, past history, special family circumstances, current counseling services, previous evaluations by outside agencies) and any other information that may help us better assist your child:

_____

_____

_____

_____

_____

_____

_____

Parent/Guardian Signature **Date**