Dutch Fork Psychological Services, LLC

Pre-Evaluation History Form

The following questions are asked so that we can best understand your child. Please fill out this questionnaire before the child is evaluated. Please read the questions carefully and answer them as fully as possible. Use the back of the sheet if necessary. If there are any questions you don't understand, they can be filled out with the examiner's help when we review the history with you.

Please put a star (*) next to such questions.

Today's Date _____

Child's History

Legal Name _____ Birth Date _____ Age _____

Street Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Child's Doctor _____ Phone _____

What are the problems that caused you to seek help for this child? _____

_____

_____

Family History

Child is living with:

☐ Both parents ☐ Mother ☐ Father ☐ Mother and Stepfather

☐ Father and Stepmother ☐ Legal Guardian ☐ Foster Parents

☐ Other (please specify) _____

Is the child adopted? ☐ Yes ☐ No If yes, with which parent(s), if any, does the child live?

☐ Natural ☐ Adoptive Child's age at adoption _____

Status of parents' marriage:

☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

How long married? _____ How long divorced? _____ Child's age at divorce _____

	Birth Mother	**Birth Father**
Age:	_____	_____
Highest grade completed:	_____	_____
Diploma/Degree:	_____	_____
Occupation:	_____	_____

Birth Mother **Birth Father**

Please describe any special education or tutoring:

_____ _____

Please describe any grades repeated or subjects failed:

_____ _____

Please describe any learning difficulty, and subject and grade level at which it occurred:

_____ _____

Please describe any behavior problems and treatment received:

_____ _____

Please describe any psychological or psychiatric problems for which treatment was received:

_____ _____

Any Attention-Deficit Disorder or hyperactivity? Please describe treatment:

_____ _____

	Adoptive Mother or Stepmother or Other _____ (circle one)	**Adoptive Father or Stepfather or Other _____ (circle one)**
Age:	_____	_____
Highest grade completed:	_____	_____
Diploma/Degree:	_____	_____
Occupation:	_____	_____

Other Children
(Including step-siblings and half-siblings)

Name	Age	Sex	In home?	School / behavioral / health problems

Biological Extended Family

Do any extended family members (maternal/paternal grandparents, uncles, aunts, cousins) suffer from a problem with inattentiveness or hyperactivity; epilepsy; seizures; migraines; alcoholism or substance abuse; psychological, emotional, or personality difficulties; learning problems or developmental disabilities; and/or a "nervous" or neurological disorder?

☐ Yes ☐ No If yes, please list relationship to child, disorder, and any treatment received:

Maternal (mother's side)	**Paternal (father's side)**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please provide any other information about the child's extended family that might help us understand the child's needs (medical, developmental, behavioral, educational, emotional, or psychological).

_____

_____

_____

Birth and Developmental History

PREGNANCY

Length of pregnancy in months _____

Any illnesses or complications while pregnant? ☐ Yes ☐ No

If yes, please explain: _____

_____

Medication taken by the mother *during* pregnancy? _____

Substances used *during* pregnancy:

☐ Cigarettes How many? ____ per (☐ day ☐ week ☐ Month)

☐ Alcohol How many drinks? ____ per (☐ day ☐ week ☐ Month)

☐ Drugs Please describe type(s) of drug, frequency of use, and at what month of pregnancy use was stopped (if applicable):

_____

_____

Was the father taking any medications or drugs at time of conception? If so, what? _____

_____

How many pregnancies and/or miscarriages has the mother had? _____

LABOR AND DELIVERY

Was the birth of the child "normal"? ☐ Yes ☐ No If no, please explain: _____

_____

Do you think the child's problems might be related to pregnancy, labor, or delivery? ☐ Yes ☐ No

If yes, please explain: _____

PERINATAL HISTORY

Birth weight _____ Length _____ APGAR scores _____

Did mother or baby stay in Special or Intensive Care? ☐ Yes ☐ No

Please describe any problems: _____

_____

Please list any birth defects: _____

INFANCY AND EARLY CHILDHOOD

Please rate the child on the following behaviors. Circle *1* if the behavior on the left was present the majority of the time. Circle *5* if the behavior on the right was present the majority of the time. Levels in between are represented by *2*, *3*, and *4*. If there are two behaviors listed (e.g., tantrums and head-banging), please check all that apply.

quiet and content	1	2	3	4	5	colicky and irritable
very easy to feed	1	2	3	4	5	daily feeding problems
slept well	1	2	3	4	5	frequent sleeping problems
usually relaxed	1	2	3	4	5	often restless
underactive	1	2	3	4	5	overactive
cuddly, easy to hold	1	2	3	4	5	did not enjoy cuddling
easily calmed down	1	2	3	4	5	☐ tantrums ☐ head-banging
cautious and careful	1	2	3	4	5	☐ accident prone ☐ daredevil
coordinated	1	2	3	4	5	uncoordinated
enjoyed eye contact	1	2	3	4	5	avoided eye contact
liked people	1	2	3	4	5	disliked contact with people

Other problems or comments regarding infancy or early childhood development: _____

_____

Did any event, health condition, separation, etc., disturb early infant-mother bonding or the developing toddler-mother relationship? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

Please describe the child **as an infant** (temperament, sleeping, eating patterns, etc.): _____

_____

_____

Age at Milestones

Gross Motor: crawled _____ walked _____ ran well _____

Fine Motor: fed self with spoon _____ scribbled _____ tied shoes _____

Language: used single words _____ used sentences (2+ words) _____

described activity _____

Social/Adaptive: potty trained/day _____ potty trained/night _____

Rate of development overall: ☐ Slow ☐ Normal ☐ Fast

Medical History

Has the child been taken to the emergency room with a serious emergency, hospitalized, or had outpatient surgery since birth? ☐ Yes ☐ No If yes, please describe condition/injury, treatment, any surgery, when, how long, and where: _____

_____

_____

_____

_____

_____

If the child had a head injury, did he or she lose consciousness? ☐ Yes ☐ No

If so, how long? _____

Was he or she comatose? ☐ Yes ☐ No If so, how long? _____

Do you see the child as being ☐ hyperactive? ☐ inattentive? ☐ a behavior problem?

Does the child seem to be able to control his or her behavior and attention? ☐ Yes ☐ No

Please explain: _____

_____

_____

Has the child ever been diagnosed by a psychologist, psychiatrist, or other professional as having ADHD (Attention-Deficit/Hyperactivity Disorder)? ☐ Yes ☐ No

If yes, when? _____

What treatment (**not medication**) has the child had for ADHD? _____

_____

What **medication** (include dosage and times) has the child received for ADHD? _____

_____

_____

Please describe any other handicapping conditions or special health consideration and their treatments: _____

_____

Date of last hearing test: _____ Were the results normal? ☐ Yes ☐ No If no, please explain: _____

_____

Date of last vision test: _____ Does the child wear ☐ Glasses? ☐ Contacts?

If so, why? _____

Please list medications (with dosage and times) currently being taken by the child, including nonprescription medications (excluding those listed above for ADHD): _____

_____

_____

The child's current health is: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Behavioral and Mental Health History

Please describe any behaviors that are particularly concerning to you or others: _____

_____

_____

Please list any unusual, traumatic, or possibly stressful events in the child's life that you think may have had an impact on his or her development and current functioning. Include incident, child's age at the time, and comments.

_____

_____

_____

_____

Has the child or family received any professional mental health treatment, such as individual or family counseling, group counseling, etc? ☐ Yes ☐ No Please list any past and current treatments, including type of counseling, person counseled, name of counselor, and length of treatment.

_____

_____

_____

PRESENT PERSONALITY AND BEHAVIOR

Please circle all traits that apply to the child **now**:

sad	happy	leader	follower	moody
friendly	quiet	overactive	independent	dependent
sensitive	affectionate	fearful	cooperative	tantrums
lethargic	too responsible	trouble sleeping	hard to discipline	irritable
even tempered	aggressive	prefers to be alone		

Educational History

Did the child attend preschool or daycare? If so, list location, type of program, number of days per week, age when started, progress: _____

_____

Current grade and school: _____

List previous schools and grades attended at each: _____

_____

_____

Briefly describe the child's performance and any concerns in each grade:

Kindergarten _____

1st grade _____

2nd grade _____

3rd grade _____

4th grade _____

5th grade _____

Middle School _____

High School _____

Has the child been placed in special education programs currently or in the past? ☐ Yes ☐ No

Category _____

☐ Learning Disability (LD): Subjects _____

☐ Language Disorder: Type _____

☐ Tutoring: Subjects _____

Additional Information

Please attach results of any previous testing.

Please add any additional comments you think might be helpful:

_____

_____

_____

_____

_____

Signature: _____ Date: _____
(Individual completing form)

Relationship to child: _____

Please return completed form to:

Dutch Fork Psychological Services, LLC
7313 College Street
Irmo, SC 29063

Or fax to (803) 807-9104