



Stein Psychological Associates, Inc.

assessment ▪ therapy ▪ consultation

CHILD INFORMATION

Name of Child: _____ Date: _____

Home Address: _____
Street City Zip Code

Birth Date: _____ School: _____

Grade: _____ Teacher: _____

Name of Mother: _____ Occupation: _____

Home Address: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ E-mail: _____

Name of Father: _____ Occupation: _____

Home Address: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ E-mail: _____

Physician: _____ Phone #: _____

Please describe your living arrangements:

Name Age Relationship

Name Age Relationship

Name Age Relationship

Name Age Relationship

INTAKE INFORMATION

Why are you seeking testing for your child at this time?

Check any symptoms your child has exhibited in the past six months:

- | | |
|--|---|
| <input type="checkbox"/> Sadness/Crying Spells | <input type="checkbox"/> Nervousness/Jittery |
| <input type="checkbox"/> Socially Isolated | <input type="checkbox"/> Irritable/Temper Outbursts |
| <input type="checkbox"/> Appetite/Weight Loss | <input type="checkbox"/> Persistent Thoughts |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Excessive Sleep | <input type="checkbox"/> Excessive Worrying |
| <input type="checkbox"/> Giving Up Easily | <input type="checkbox"/> Fidgety |
| <input type="checkbox"/> Difficulty Having Fun | <input type="checkbox"/> Excessive Nightmares |
| <input type="checkbox"/> Excessive Anger/Hostility | <input type="checkbox"/> Difficulty Sleeping in Own Bed |
| <input type="checkbox"/> Suicidal Thoughts/Statements | <input type="checkbox"/> Very Active |
| <input type="checkbox"/> Difficulty with Authority Figures | <input type="checkbox"/> Easily Distracted |
| <input type="checkbox"/> Often in Trouble | <input type="checkbox"/> Has Conflicts with Peers |
| <input type="checkbox"/> Argumentative | <input type="checkbox"/> Doesn't Follow Directions |
| <input type="checkbox"/> Other (please describe): _____ | |

List and describe any history of emotional disorder(s) in your child's biological family:

List and describe any significant life events (e.g. divorce, death in family, etc.):

List and describe your child's current or historical physical problems (e.g. weight gain, headaches, hypoglycemia, etc.): _____

Date of last hearing test _____ Were the results normal?
Date of last vision test _____ Were the results normal?

Does the child wear:

glasses Contacts N/A

List any medication(s) and dosage your child is currently prescribed: _____

What are your child’s strengths and hobbies? _____

BACKGROUND INFORMATION:

Did the mother experience any emotional strain during pregnancy?

Did the mother smoke during pregnancy? If so what amount?

Did the mother drink any alcohol during pregnancy? If so, how much?

Type of birth: pre-mature full-term

Length of time during labor?

Birth weight: _____

Length: _____

Infancy and Early Childhood:

(From Birth to 2 years) Please rate regarding your child’s temperament below

Example:

1 “my child can best be described as quiet and content”

5 “my child could best be described as colicky and irritable”

3 “my child was somewhere between quiet and irritable”

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
Cautious and careful	1 2 3 4 5	accident prone
Coordinated	1 2 3 4 5	uncoordinated
Enjoyed eye contact	1 2 3 4 5	did not enjoy eye contact
Liked people	1 2 3 4 5	disliked contact with people

Age at Milestones (If not known, if you felt it was developed at appropriate age):

Gross Motor: crawled _____ walked alone _____
 ran well _____

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

Language:

Used single words _____
 Used sentences (2 + words) _____

Social/Adaptive:

Potty Trained/daytime _____ potty trained/nighttime _____

Rate of Development overall:

Slow Normal Fast

EDUCATIONAL HISTORY

School child currently attends?: _____

Briefly describe how you feel your child functions academically and behaviorally at school?

Have there been any changes in the child's grades or teacher evaluations? _____

Has there ever been a recommendation to retain him/her?

Relationship History:

Is your child active in any clubs, sports or organizations?

Does your child have a satisfactory number of friends that he/she plays with on a regular basis?

Thank you for completing this form. Please bring this form to your initial testing appointment.