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Initial Evaluation Questionnaire

Person Completing Form: _____ Relationship: _____ Date: _____

Patient's Name _____ Sex: M / F

Date of Birth: _____ Age: _____ Primary Phone#:_____

Address:_____City/Zip:_____

Mother: _____

Preferred Phone: _____ (type _____) Phone 2: _____ (type _____)

Employer: _____Work Phone:_____
Address:_____City/ST/zip:_____
Email Address: _____

Father:_____

Preferred Phone: _____ (type _____) Phone 2: _____ (type _____)

Employer: _____Work Phone:_____
Address:_____City/ST/zip:_____
Email: _____

Are both parents listed above the biological parents? □Yes □No
If no, please explain: _____

Patient lives with (circle): Mother&Father Mother Father Legal Guardian Other: _____
Name & Ages of Siblings: _____

IN CASE OF EMERGENCY:
Name of local friend or relative (not living at same address): _____

Relationship to child: _____ Main phone: _____ 2nd phone: _____

What languages are spoken in the home? What is the dominant language? _____

Referred by:_____ Phone: _____

If referred by physician, reason for referral or ***Parental Concerns***:

Please list all physicians, professionals or specialists who follow your child and specialty:

1. Physician, professional, or specialist:

   Specialty:

2. Physician, professional, or specialist:

   Specialty:

3. Physician, professional, or specialist:

   Specialty:

4. Physician, professional, or specialist:

   Specialty:

5. Any additional physicians or specialists and their area of expertise:

Prenatal and Birth History:

Mother's general health during pregnancy (illnesses, accidents, medications, etc.).

Birth weight:_____ **Mother's age at child's birth:** _____

Pregnancy: □Normal □Difficult **Term**: □Full □Pre-mature (# of weeks) _____

Birth: □Caesarian □Vaginal **Length of Labor:** _____

Please circle all that apply to the child at or shortly after birth:

Twin Jaundiced Breech Forceps used Cord around neck

Was your child admitted to NICU (how long?) _____ Oxygen administered? Feeding tube?

Any other considerations at birth/pregnancy/Were there any unusual conditions that may have affected the pregnancy or birth?

Medical History:

Describe current health:_____ height: _____weight: _____

Medical Diagnoses: _____

Please list all surgeries & dates since birth:_____
_____

Hospitalizations & Dates:_____

Major IIlnesses:_____

Current Medications:_____

Current Supplements/Vitamins: _____

Is your child up to date with all immunizations: □ Yes □ No-explain: _____

Allergies: _____

History of Asthma? □Yes □No If yes, how is it currently controlled? _____

History of Ear Infections? □Yes □No If yes, were ear tubes placed? □Yes □No

If yes? When? _____

History of Seizures? □Yes □No If yes, please provide details as to when and possible causes/triggers:
_____

Does your child have any assistive devices? □Yes □No If yes please list:

Formal hearing evaluation?□Yes □No Where?_____Results:_____

Formal vision evaluation? □Yes □No Where?_____Results:_____

Formal dental evaluation? □Yes □No Name of dentist: _____
Results of Dental evaluation:

Have any other specialists (physicians, audiologists, physical therapists, psychologists, special education teachers, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions.

Have there been any recent (within the last year) major life changes for your child?
Please explain:

Moving to a new home: _____

Moving to a new city: _____

Changing schools: _____

Family separation/divorce: _____

Family members leaving home: _____

Prolonged illness or death of significant family member: _____

New baby or child in the home: _____

New family members moving into the home: _____

Significant family stress: _____

Other changes/stressors: _____

Has your Child ever been in therapy (e.g. Occupational Therapy, Speech Therapy, Psychotherapy, Physical Therapy)? Please indicate what type and when, and who the provider was.

Start date – End date	Type of Therapy	Provider Name	Provider contact information

Family history – check all that apply:

Are there any of the following medical problems on either side of the child's BIOLOGICAL parents' families? If YES, please indicate on which side of the family, MOTHER or FATHER and explain WHO this is in relation to the CHILD. **Please explain the history**

	No	**Yes**	**Mother or Father's side ?**	**Who? (as related to your child)**	**Explanation**
Birth defects/Congenital disorder					
Neurological disorder or seizure disorders					
Delayed Motor Development (walking, crawling, etc)					
Hearing Loss					
Senses problems - vision, hearing, touch, taste, smell, balance					
Swallowing or feeding problems (eg. described as picky eater as child, esophageal strictures)					
Learning problems					
Hyperactivity/ADHD/ADD					
Autism Spectrum Disorder					

	No	Yes	Mother or Father's side ?	Who? (as related to your child)	Explanation
Developmental therapy (e.g. Speech therapy, Physical therapy)					
Alcohol/drug use					
Psychological/nervous issues					
Special Education/Special Classes at school					
Behavioral Disorders/Problems					

Have any of the child's siblings ever demonstrated delayed language skills, delayed physical or language milestones, academic difficulties, social difficulties or other disorders?

Does your family have any spiritual, cultural, and/or religious beliefs that influence the child?

Educational/Social History

Current School/Day Care: _____ Grade/Class Type: _____
School Hours per day/week: _____

Previous schooling situations:

How is your child currently doing academically (or preacademically)?

Has your child ever demonstrated difficulty with reading fluency or comprehension? If yes, please explain:

If applicable, how is your child's written language?

Handwriting:

Putting ideas into writing:

Does the child receive special services at school (ex. speech therapy, occupational therapy, music therapy, adaptive PE etc.? If yes, describe.

If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? If yes, describe some of the goals.

Describe your child's preschool experience? (how did they interact with peers there? How many years did they attend at the same school? How many different preschools did they attend? Were they ever asked to leave a preschool and if so why? Etc.).

Describe homework time at your house:

Where does your child do homework? _____

How long does an average homework session usually take? _____

What is your child's independence level with homework? (circle and explain)

Totally independent Needs a little help Needs a lot of help Needs full adult assistance

Explain:

Describe your child's mood/behavior during homework:

Has your child had problems with any of the following (beyond expected for child's age) **please explain any difficulties**:

	No	Yes	Explanation
Misses important details while reading			
Trouble sounding out words			
Can't remember words by sight, has to sound them out			
Guessing/making frequent mistakes while reading			

	No	Yes	Explanation
Reads very slowly or very quickly			
Difficulty understanding what is read			
Appears anxious/uptight/nervous while reading			
Makes careless mistakes while solving math problems			
Knowledge of basic math facts is not at grade level			
Difficulty solving story/word problems			
Appears anxious/uptight/nervous when working with math			
Trouble forming letters/words			
Presses too hard or too soft with the pencil while writing			
Others often have difficulty reading what the child has written			
Difficulty holding the pencil or pen correctly			
Difficulty with typing/ learning to type			
Writes overly large or overly small letters and words			
Takes a very long time to write			
Trouble staying on the line while writing			
Difficulty with spacing between letters and words while writing			
Poor spelling in writing			
Poor spelling aloud			
Appears anxious/worried/nervous while writing			
Has difficulty coming up with items/topics to write about			
Uses simple sentence structure/ lacks variety in writing			

Developmental History

We would like to have information about your child's developmental milestones. Indicate the age when your child first did each of the following INDEPENDENTLY. If you cannot recall/find a specific age, please mark whether you believe your child accomplished the milestone early, on time or late (expected age ranges are in the chart). If your child has not yet achieved the milestone, write NA in the age column.

Mileston	Expected Age	Age met	Early	On time	Late	Comments
Smiled	2 mos					
Held head up	2 mos					
Rolled over	5 mos					
Reached for an object actively	4-5 mos					
Transferred object between hands	5 mos					
Sat unsupported	6-9 mos					

Milestone	Expected Age	Age met	Early	On time	Late	Comments
Ate finger foods	9-10 mos					
Crawled	6-10 mos					
Stood alone	9-10 mos					
Walked by self	12-18 mos					
Threw objects actively	19-20 mos					
Ran by self	24 mos					
Followed simple 1 step directions	12-18 mos					
Ate unaided with a spoon/fork	24-36 mos					
Rode Tricycle	36 mos					
Dressed self	3-4 years					
Rode bicycle without training wheels	4-5 years					
Caught a thrown object	5 years					
Demonstrated handedness (which?)	2-4 years					
Knew colors	3 years					
Counted to 5	3-4 years					
Knew alphabet	4-5 years					
Started reading	6-7 years					
Bladder trained - days	2-4 years					
Bladder trained - nights	5-7 years					
Bowel trained	3-4 years					

Has your child had problems with any of the following (beyond expected for child's age) **please explain any difficulties**:

	Never	In the past only	Current concern	Explanation
Sleeping problems				
Bed wetting				
Temper tantrums				
Head banging				
Breath holding				
Less or more sensitive to pain or changes in temperature				
Aggression/ destructiveness				
Nervous habits (nail biting etc.)				
Trouble following directions				
Needs things repeated multiple times				
Difficult transitions				
Major mood swings				

	Never	In the past only	Current concern	Explanation
Odd visual behavior (ex. fixated or looking at things in unusual ways)				
Under or over reactive to sounds				
Under or over reactive to taste				
Difficulty with the feel of clothing or other objects (ex. tags, seams, tight clothes, jeans, rough surfaces etc.)				
Under or over reactive to smell				
Difficulties dressing self				
Muscle weakness/tightness				
Clumsy or awkward coordination				
Difficulties with walking/running				
Poor fine motor skills (ex. Using a pencil, scissors)				
Difficulties with handwriting				
Tics, involuntary or repetitive movements				
Poor balance (ex. Tripping, falling, etc.)				
Trouble with gross motor sequences (ex. dance moves, martial arts routines etc.)				
Any unusual fears?				
Shows right/left confusion				
Difficulties coloring within the lines				
Difficulties with drawing/copying				
Difficulties with puzzles				
Short attention span or difficulty paying attention				
Forgets information quickly				
Difficulty attending to more than one thing at a time				
Easily gets off task and/or has trouble completing tasks				
Loses track while reading and needs to re-read				
Gets motion sick (car sick)				
Inattentive to details/makes careless mistakes				
Does not seem to hear anything else during screen time				
Seems to get overwhelmed with difficult tasks				

	Never	In the past only	Current concern	Explanation
Lacks strategies to memorize while learning/studying				
Problems copying from board or taking notes				
Forgets where personal items or school work were left				
Lies/distorts truth				
Makes the same kind of errors over and over				
Struggles with perfectionism/ has to be perfect				
Quickly becomes frustrated and gives up easily				
Appears to be undermotivated to perform or behave appropriately for age				
Has trouble controlling emotions (ex. becomes angry, sad, excited too quickly or too intensely)				
Does not cope with disappointment perceived from parents or others				
Apprehension or fear in new situations or with new people- in ways that impact his/her functioning				
Does not know where to start when given a task				
Difficulty stopping one activity and starting another				

Daily Life:

Describe your child's sleep habits:

What are your families rules about screen/electronic device time?

About how long is your child normally on screens/electronic devices:

- On Weekdays/School days: _____
- On weekends/holidays? _____

How hard is it to get your child to leave screens/electronic devices?

With whom does the child spend the most of his or her time?

Describe your child's reactions to new experience and/or changes in their routine (ex. Staying at a hotel, driving a different route to school, eating at a new restaurant, running unexpected errands, cancelled/rescheduled plans etc.):

Does your child have any self-stimulatory behaviors? If so, please describe:

Does your child ever exhibit aggressive behaviors towards themselves or others? (If so, please describe and list possible triggers)

Who are your child's closest friends (put a star by their best friend)?

How does the child interact with other adults (e.g., friendly, outgoing, bossy, shy, aggressive, uncooperative)?

How does the child interact with other children (e.g., friendly, outgoing, bossy, leader, follower, shy, aggressive, uncooperative)?

Describe your child in a social situation, such as a family party or a play group. Please describe events with familiar and unfamiliar people:

	With familiar people	With unfamiliar people
How does your child act?		
What does your child say?		
Where is he/she in relation to other children? (ex. In the middle of the action, away from the group, alone, the leader etc.).		
Is he/she engaged/aloof/anxious/shy etc. in the social interaction?		
Does your child seem to be able to participate in the group like other children at the event?		
How does your child feel about going to social events?		

How does your child behave/perform with the following tasks?

	Easy for him/her	Somewhat hard for him/her	Very difficult for him/her	Explain please:
Novel situations				
Going to a new place				
Routine tasks (ex. Getting ready for bed, brushing teeth etc.)				
Homework				

	Easy for him/her	Somewhat hard for him/her	Very difficult for him/her	Explain please:
Finding possessions or lost objects when motivated to find them				
Time management				
Cleaning his/her room				
Backpack organization				
Navigating to familiar places or through familiar stores/locations				
Chores				
Getting self ready for common activities (ex. School)				
Long term project planning				
Studying for tests				
Getting self ready for less common activities (ex. Sports, sleepover, etc.)				
Using school planner/organizer				
Remembering what homework assignments he/she has				
Turning in homework				
Remembering to get things signed by parents and returned to school				
Making decisions				

Feeding/Chewing/Swallowing:

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, gagging)? If yes, please describe:

Was your child breast or bottle fed?: _____

Did your child have any difficulties learning to bottle/breast feed:

When was he/she weaned?: _____

Was there any difficulty weaning your child from the bottle/breast?

Did/does your child suck his/her thumb or pacifier (now or prior): □Yes □No

If yes, which one: _____

If it was prior, when did he/she stop: _____

Describe your child's current eating habits/schedules:

Describe "meal times" at your house and how your child participates (ex. all family sits at table, kids graze when they want to, eat on couch while watching TV etc.):

What are your child's 3-5 favorite foods (put a star by the very favorite ones)?

What kind of cup(s) does your child drink from (ex. bottles, sippy cups, straws, open cups)?

Describe your child's current diet (ex. Any prescribed diets, any extreme food preferences, any special diets followed by your family, or a basic description of your child's diet):

Does your child like any unusual foods or combinations of foods or does your child have any food preferences based on color, shape, or flavor (sweet, salty, sour)? If yes, please explain:

Is there anything "different" or "unusual" about the way your child eats food (ex. doesn't like to bite, small bites, stuffs mouth full, etc.)?

Indicate any aversions/problems or preferences your child may have. Included are examples of each food group:

	Likes	Dislikes	Refuses	Difficulty Managing
Thin Liquids (ex. water)				
Thick Liquids (ex. milkshakes)				
Purees (ex. pudding)				
Textured puree (ex. applesauce, mashed potatoes)				
Mixed texture (ex. cereal with milk, or jello with fruit)				
soft solids (ex. banana, cheese, chicken nuggets)				
crunchy solid (ex. Goldfish, cracker)				
Hard to chew solid (ex. Raw carrots, steak, apples with peels)				
cold foods				
room temperature foods				
warm foods				

Speech/Language:

At what age did your child:

Cooed: _____ Babbled: _____

Used single words (e.g., *no*, *mom*, *doggie*): _____

Combined words (e.g., *me go*, *daddy shoe*): _____

Named simple objects (e.g., *dog*, *car*, *tree*): _____

Used simple questions (e.g., *Where's doggie?*): _____

Engaged in a conversation: _____

Did your child ever gain language and then lose any language/words for a brief or extended period of time?

Has your child ever had any difficulty with understanding or using pronouns (I, me, we, us, he, she, them etc.) correctly after the age of 3?

How does the child usually communicate his/her wants/needs? (gestures, single words, short phrases, sentences?)

Can you understand your child? yes no sometimes

What percentage of the time can you understand him/her? 80-100% 50% 50% or less

Can other family members/teachers understand his/her speech? yes no sometimes

Can strangers understand his/her speech? yes no sometimes

How often would you guess that strangers can understand him/her? 80-100% 50% 50% or less

What does your child do when he/she is not understood?

Has your child had problems with any of the following (beyond expected for child's age) **please explain any difficulties**:

	Never	**In the past only**	**Current concern**	**Explanation**
Stuttering/ Stammering				
Drooling or Breathing through mouth				
Plays with objects or toys in a manner that is unusual or different from what is intended				
Is rigid about following rules				
Trouble sharing easily				
Play doesn't include pretend themes, only copies events from movies or books				
Difficulty making up own games or adapting old games with new rules or variations				
Play is disorganized, jumps from one activity to another				
Easily bored and seems poor at entertaining self when alone				
Facial expressions do not match communication or emotion				
Talks too fast or too much for situations				
Starts conversations in the middle of ideas (doesn't recognize that others are missing important info or context)				
Unintentionally makes offensive statements or doesn't give compliments				
Doesn't greet, say goodbye or other niceties (without being prompted)				
Doesn't read others' emotional states before talking				
Doesn't get jokes, sarcasm, or friendly teasing				
Thinks everyone is bullying him/her or sometimes comes across as a bully to others				
Poor reciprocity (doesn't show interest in other people)				
Violates personal space/privacy of other people				
Frequently says things that are off topic				
Difficulty making eye contact				

	Never	**In the past only**	**Current concern**	**Explanation**
Difficulty describing his/her own emotions				
Doesn't know how to compromise or accommodate to other's wishes				
Difficulty finding the right words to say				
Intrudes or doesn't take turns in conversation				
Body language or gestures missing or unusual				
Voice is too loud or too soft for situations				
Struggles with getting thoughts onto paper (writing assignments)				
Forgets what happened early in the day				
Forgets what happened days or weeks ago				
Recalls information inaccurately				
Insists he/she are always right and/or tries to make everyone always follow the "rules"				
Trouble with speech prosody (ex. monotone, unusual pitch or inflection)				

Describe your child's difficulties or deficits in your own words:

When was the problem first noticed? By whom?

Has the problem changed since it was first noticed? Please explain:

Do you think your child aware of the problem? If yes, how does he or she feel about it?

Please list any items that your child enjoys or that are reinforcing for him/her: (ex. toys, foods, trains, social reinforcers like tickles etc)

Provide any additional information that might be helpful in the evaluation or remediation of the child's problem.

What are your goals/expectations for therapy? What do you hope therapy will accomplish (long and/or short-term goals)?

Person completing form:_____

Relationship to client:_____

Signed:_____ Date:_____