Dr. Timothy L. King

Dear Parents:

A comprehensive assessment of your child necessitates a thorough understanding of all background information relevant to your current concerns about your child. In preparation for your intake session, please complete this form either online or download it and mail to us as soon as possible.

DATE ________________

CHILD'S NAME ________________________________ BIRTHDATE ____________ AGE _______

SCHOOL _____________________________________ GRADE ________________ SEX _______

HOME ADDRESS ____

HOME PHONE ____________________ BUS PHONE __________________________________
Mother Father

MOTHER OR GUARDIAN

NAME ______________________________

AGE ________ Date of Birth ____________

EMPLOYED YES _____ NO _____

OCCUPATION _______________________

EMPLOYER __________________________

EDUCATION _________________________
Highest grade/degree achieved

FATHER OR GUARDIAN

NAME ______________________________

AGE ________ Date of Birth ____________

EMPLOYED YES _____ NO _____

OCCUPATION _______________________

EMPLOYER __________________________

EDUCATION _________________________
Highest grade/degree achieved

IS CHILD LIVING WITH BOTH NATURAL PARENTS? YES _____ NO _____

IF NOT, PLEASE EXPLAIN ____

IF PARENTS ARE SEPARATED/DIVORCED, FOR HOW LONG HAVE THEY BEEN SEPARATED?

____

CHILD'S RELATIONSHIP WITH NON-CUSTODIAL, NATURAL PARENT? HOW OFTEN DOES CHILD SEE NON-CUSTODIAL PARENT? ____

____

BROTHERS AND/OR SISTERS

NAME	SEX	AGE	GRADE & SCHOOL/OCCUPATION

OTHER PERSONS IN THE HOME

NAME	RELATIONSHIP	AGE

DO YOU FEEL YOUR CHILD IS HAVING DIFFICULTIES AT SCHOOL? ____________________________

AT HOME? ____

IF SO, WHAT DO YOU CONSIDER THE PROBLEM? _____________________________________

____

WHEN AND HOW DID THE PROBLEM BEGIN? ____

____

ARE THERE ANY PAST OR PRESENT CIRCUMSTANCES WHICH YOU THINK COULD BE RELATED TO YOUR CHILD'S PRESENT DIFFICULTIES? ____

____

COMMENT ON FAMILY RELATIONSHIPS ____

____

FAMILY HISTORY (check if any apply)

	Mother	Father	Siblings	Other Relatives
Learning Problems	___	___	___	___
Attention Problems	___	___	___	___
Emotional Problems	___	___	___	___
Substance abuse/addiction	___	___	___	___

COMMENTS/EXPLANATIONS ____

CHILD'S HISTORY

BIRTH WEIGHT __________ MONTHS CARRIED __________ HOURS IN LABOR ___________

MOTHER'S AGE AT DELIVERY __________ HEALTH DURING PREGNANCY __________________

COMPLICATIONS DURING PREGNANCY OR BIRTH ____________________________________

____

CHILD'S GENERAL BEHAVIOR, EATING, SLEEPING AS AN INFANT AND TODDLER, DESCRIBE

____

____

PLEASE PROVIDE APPROXIMATE AGES FOR THE FOLLOWING:

Sat up	___	First words	___	Sentences	___
Walked	___	(other than mama, dada)		Toilet Trained	___

HEALTH HISTORY

DATE OF LAST PHYSICAL EXAM __________ RESULTS ___________________________________

HEIGHT __________ WEIGHT __________

SERIOUS ILLNESSES, INJURIES, HOSPITALIZATIONS, OPERATIONS (please explain and include dates) ____

____

PLEASE CHECK ANY AREAS YOU THINK ARE A PROBLEM FOR YOUR CHILD

_____ Eating
_____ Sleeping
_____ Bedwetting
_____ Toileting problems
_____ Nail Biting
_____ Thumbsucking
_____ Temper Tantrums
_____ Lying
_____ Nightmares
_____ Getting along with friends
_____ Overactive
_____ Self-help skills (dressing, bathing, etc)
_____ Short attention span
_____ Easily frustrated
_____ Stealing
_____ Fears: describe _________________

MEDICAL/PHYSICAL CONDITIONS (check those that apply)

_____ Asthma
_____ Allergies
_____ Seizure disorder
_____ Cerebral Palsy
_____ Chronic ear infections
        _____ tubes
_____ Diabetes
_____ Tourette's Syndrome
_____ Attention Deficit/Hyperactivity Disorder
_____ Other ____________________________

ALL CHILDREN EXHIBIT, TOM SOME DEGREE, THE FOLLOWING BEHAVIORS. CHECK THOSE THAT YOU BELIEVE YOUR CHILD EXHIBITS TO AN EXCESSIVE DEGREE COMPARED TO OTHERS HIS/HER AGE.

___ Fidgets with hands, feet or squirms in seat
___ Has difficulty remaining seated when must do so
___ Easily distracted by extraneous stimulation
___ Blurts out answers to questions before they are completed
___ Difficulty paying attention during tasks or play activities
___ Shifts from one uncompleted activity to another
___ Has difficulty playing quietly
___ Often talks excessively
___ Interrupts or intrudes on others
___ Does not appear to listen to what is being said
___ Loses things necessary for activities
___ Boundless energy and poor judgment
___ Impulsivity/poor self control
___ Difficulty waiting turn
___ Fails to give close attention to detail
___ Difficulty organizing tasks
___ Acts like he or she is driven by a motor
___ Excessive number of accidents
___ Doesn't seem to learn from experience
___ Avoids tasks that require a sustained mental effort

AT WHAT AGE(S) DID YOU FIRST NOTICE THESE BEHAVIORS ____________________________

HAS YOUR CHILD EVER EXPERIENCED OR BEEN WITNESS TO ANY TRAUMATIC EXPERIENCES? IF YES, EXPLAIN ____________________________

EDUCATIONAL HISTORY

HAS YOUR CHILD BEEN INVOLVED IN A PRESCHOOL EARLY INTERVENTION PROGRAM?

EXPLAIN ____

____

DID YOUR CHILD ATTEND NURSERY SCHOOL? __________ AGES ________________________

COMMENTS BY NURSERY SCHOOL TEACHERS ABOUT YOUR CHILD'S BEHAVIOR

____

LIST SCHOOLS ATTENDED BY CHILD (INCLUDE NURSERY AND KINDERGARTEN)

NAME	LOCATION	GRADE	REASON FOR LEAVING

WERE YOU CONCERNED ABOUT YOUR CHILD'S ABILITY TO SUCCEED IN KINDERGARTEN? IF YES, EXPLAIN ____

DID CHILD ATTEND PRE-FIRST? ____ HAS CHILD REPEATED A GRADE? ____ WHICH GRADE ____

HAVE YOUR CHILD'S TEACHERS EVER COMPLAINED ABOUT THE FOLLOWING?

____ Doesn't sit still in seat
____ Frequently gets up and walks around the classroom
____ Shouts out, doesn't wait to be called on
____ Won't wait his/her turn
____ Doesn't cooperate well in group activities
____ Acts without thinking
____ Daydreams/lost in own thoughts
____ Doesn't pay attention during large group lesson
____ Does better in one-to-one situations
____ Doesn't respect the rights of others
____ Doesn't complete work
____ Messy work

COMMENTS ____

PREVIOUS EVALUATIONS (check those that apply, with dates and where it was done)

______ Psychological ____

______ Psychiatric ____

______ Speech/Language ____

______ Neurological ____

______ Other ____

PREVIOUS THERAPY

______ Psychotherapy/Counseling ____

______ Speech/Language ____

______ Physical Therapy ____

______ Occupational Therapy ____

REACTIONS AND IMPRESSIONS

CHILD'S FEELINGS ABOUT SCHOOL ____

____

HOW DO YOU FEEL ABOUT YOUR CHILD'S SCHOOL ____

____

PLEASE LIST CHILD MAJOR INTERESTS AND HOBBIES ____

____

FRIENDS: MALE - How many? ______ Age Range ______
FEMALE - How many? ______ Age Range ______

COMMENTS ON PEER RELATIONSHIPS ____

____

WE ARE INTERESTED IN YOUR COMMENTS AND IMPRESSIONS ABOUT YOUR CHILD. PLEASE INCLUDE CHILD'S STRENGTHS AND WEAKNESSES

MOTHER'S COMMENTS____

____

____

____

____

FATHER'S COMMENTS ____

____

____

____

____

____

SIGNATURE OF MOTHER ______________________________ DATE ______________

SIGNATURE OF FATHER ______________________________ DATE ______________

SIGNATURE OF PERSON COMPLETING THIS FORM IF OTHER THAN PARENT

____ DATE ______________

RELATIONSHIP TO FAMILY ______________________________________

FAMILY DOCTOR'S NAME, ADDRESS AND PHONE NUMBER

____

We thank you for assisting us in helping your child by completing this survey.