No-Show/Late Cancellation Policy

I understand that failure to show up for my (or my child's) scheduled appointment with provider Dr. Colleen Daniel will result in my being charged the full hourly rate of $200. For appointments over 60 minutes in duration, I will be charged for the full amount of time scheduled.

I understand that failure to cancel my (or my child's) appointment by 3pm one business day before my scheduled appointment (or by Friday at 3pm for Monday appointments) will result in my being charged her full hourly rate of $200/hour.

I understand that all no-show fees will be billed to the credit card I have on file with Coastal Neuropsychological Specialists unless alternative payment arrangements are made.

I understand that no show/late cancellation fees are **not** covered by my health insurance, and that I am responsible for paying all late and no-show fees for myself or child.

I understand that I need to contact the office at (657)223-1690 to cancel or reschedule appointments.

Patient Name: _____

Patient or Parent/Guardian Signature: _____

Date: _____

Electronic Communication Policy*

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

Email Communications

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

Text Messaging

Because text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. So, please do not text message me unless we have made other arrangements.

Social Media

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that

occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

Websites

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your sessions.

Web Searches

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work with you while we are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work together.

I have read and understand Dr. Daniel's electronic communication policy.

Signed:_____

Printed Name: _____ Date: _____

COLLEEN H. DANIEL, PSY.D.

CA Lic. PSY23849

Clinical Psychology and Clinical Neuropsychology

11 Mareblu, Ste. 200 Aliso Viejo, CA 92656

30211 Ave. de las Banderas, Ste. 200 RSM, CA 92688

NEUROPSYCHOLOGICAL AND PSYCHOLOGICAL TESTING INFORMED CONSENT

Welcome! You have most likely come to my office because you or your child are experiencing problems requiring further assessment. Please take a moment to read this form and ask for additional information or clarification.

Nature of My Services. I am licensed and trained to practice psychology in the state of California. I have a doctorate degree in clinical psychology from Pepperdine University. I additionally have extensive training in conducting psychological, psychoeducational, and neuropsychological assessments.

Assessment. Neuropsychological and psychological assessment includes a comprehensive evaluation of intellectual, academic, and/or emotional functioning. The evaluation will require direct contact, interviewing, and testing. I will also collect and review information from schools, psychologists, psychiatrists, and other professionals involved in your case. Depending on the number of tests being administered, we will typically meet on three or four occasions for 1 ½ to 4 hours each session. An appointment is a commitment to our work. If you need to cancel an appointment, please give me at least 24 business hours notice by telephone (**not email**). I will make every effort to re-schedule your cancelled appointment. Cancelled appointments will delay our work together and appointments not cancelled in advance will be billed at my hourly rate for each hour of our scheduled appointment time.

Foreseeable Risks and Discomforts. Some questions asked regarding yourself, your child, or your history may touch upon personal issues and uncomfortable

situations. I am not attempting to cause discomfort, but such questions are needed to obtain a comprehensive history and understanding as to the nature of your/your child's difficulties. By agreeing to participate in this evaluation, you are agreeing to cooperate to the best of your ability. In addition to distress, some individuals do experience fatigue and headaches following lengthier testing sessions.

Fees. My testing fee includes time spent on the intake interview, test administration, scoring, interpretation, report writing, consultation with other professionals involved in the case, and feedback. We will work together to set up a payment schedule. You are fully responsible for payment for these services. The process will most likely take three to four weeks. By the end of our time together, you will have better understanding of you or your child's difficulties, and you will be provided with an extensive written report and recommendations. You will also have an opportunity to ask any questions regarding the testing or testing results. Please note that your child is welcome to attend the final feedback session, if appropriate. Alternatively, you may schedule an additional feedback session for him/her to discuss these results with me in a manner more suitable to his/her developmental level. This additional feedback session will be billed at my hourly rate. According to law and ethics code, I have the right to turn over unpaid bills to a collection agency. If this should occur, I will provide you with the opportunity to pay and will notify you if I contact an agency. I will also charge in full for an appointment cancelled with less than 24 business hours notice (**i.e. not weekend days or holidays**). Cancellations must be made by telephone, not email.

INITIALS_____

Please note that I am not contracted with all insurance plans, and insurance coverage for testing is not guaranteed. I am an in-network provider for the following insurance plans: Cigna, Aetna, United, Magellan, Optum, and Medicare. I will make every attempt possible to obtain payment through your insurance company, however, should your insurance not provide coverage or payment for any services rendered, you are responsible for paying me directly at the contracted rate.

INITIALS_____

For out of network or cash pay services, I accept cash, credit card, and check. It is therefore customary to pay for all services at the time they are rendered. All checks should be made payable to Colleen Daniel, Psy.D. Returned checks are subject to a $25.00 service charge. You will be provided with a bill at the end of each session to enable you to bill your insurance company.

Please recognize that when insurance companies are used, there may be limits to confidentiality. Usually, insurance companies ask for information about duration of illness, psychiatric diagnosis, dates of service, name of treatment provider, treatment goals, and the details of the treatment session. In addition, providers are now required to sign waivers that allow the company to audit patient records. If I am subpoenaed or otherwise required to participate in a legal processing as a result of providing professional services to you, you will be responsible for paying for all time expended on preparation, transportation, and testimony. This will be billed at twice my regular rate. Similarly, school observations or consultation out of the office is also billed at 1 ½ times my regular rate, including travel time.

INITIALS _____

Certain portions of assessment are not reimbursed by insurance companies and are therefore billed separately to you. There is a $75 materials fee to cover the costs of testing supplies, computerized assessments, and computerized data interpretation. This fee is due at the first appointment.

INITIALS_____

Confidentiality. It is important for you to know about my confidentiality policy. Confidentiality is vital to treatment progress. In general, according to the law and my ethics code, what you and your child discuss with me is not shared with anyone else without your written permission. However, there are several exceptions, which are designed for your protection and safety. These exceptions include:

1) If you or your child is a victim of child abuse, or if you or your child divulges information about such abuse, I am required by law to report this to the appropriate authorities. Abuse includes, but is not limited to, physical, sexual, and emotional abuse.

2) If you or your child is a victim or perpetrator of elder or dependent adult abuse, or if you or your child divulges information about such abuse, I am required by law to report this to Adult Protective Services or other appropriate authorities.

3) If you or your child threatens harm to yourself, someone else, or the property of others, I may be required to notify the police and potential victim(s), or take other reasonable steps to prevent the threatened harm.

4) If ordered by the court, I may have to testify or release your records.

5) Per Section 215 of the Patriot Act of 2001, I may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law I cannot reveal when I have disclosed such information to the government.

I may also consult with another professional from time to time, but without identification of the patient whose case is the subject of consultation. Please also note that in the case of separation or divorce, I do not keep secrets from either parent and will need to share all information with both parents (assuming joint custody).

Maintenance of Records. Records of this evaluation will be held and maintained in accordance with California law. All information will be kept confidential as required by CA Welfare and Institution Code 5328.

Emergency Procedures. If you need to contact Dr. Daniel, you may call (657) 223-1690 and leave a message. Dr.Daniel checks messages on a regular basis and your call will be returned as soon as possible. In a life-threatening emergency, please call 911 or go to the nearest emergency room. You may also contact your community crisis hotline.

I look forward to working closely with you.

I have read and understood the information and policies described in this form. I have also been given the opportunity to ask questions, and have had my questions answered. I hereby agree to this psychological evaluation with Dr. Colleen Daniel, and to cooperate to the best of my ability, as shown by my signature below.

Signature of Patient: _____

Printed Name: _____

Date: _____

Signature of Guardian for minor patients: _____

Printed Name: _____

Date: _____

Witness, Colleen Daniel, Psy.D._____

Date: _____

CHILD
NEUROPSYCHOLOGICAL HISTORY

Child's name _____ Date _____

Address (Street, City, ST, Zip) _____

Parent's or guardian's phone (H) _____ (W) _____

Age _____ Birthdate _____ Religion _____

Sex _____ Ethnic or racial background _____

Grade and school _____

Hand child uses for writing or drawing: Right _____ Left _____ Switches between them _____

Primary language _____ Secondary language _____

Medical diagnosis (1) _____

if any (2) _____

Who referred the child for this testing? _____

Briefly describe the problem: _____

_____

What specific questions would you like answered by this evaluation?

(1) _____

(2) _____

(3) _____

THIS FORM HAS BEEN COMPLETED BY:

Name _____ Relationship to child _____

Address _____

Phone (H) _____ (W) _____

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This form was created by Glen D. Greenberg, Ph.D.

SYMPTOM SURVEY

For each symptom that applies to the child, place a check in the box. Compare the child to other children of the same age. Then, check if this is a NEW symptom (within the past year) or an OLD symptom (over one year). Add any helpful comments next to the item.

1) PROBLEM SOLVING

√	New	Old	
☐	____	____	Difficulty figuring out how to do new things
☐	____	____	Difficulty making decisions
☐	____	____	Difficulty planning ahead
☐	____	____	Difficulty solving problems a younger child can do
☐	____	____	Disorganized in his/her approach to problems
☐	____	____	Difficulty understanding explanations
☐	____	____	Difficulty doing things in the right order (sequencing)
☐	____	____	Difficulty verbally describing the steps involved in doing something
☐	____	____	Difficulty completing an activity in a reasonable period of time
☐	____	____	Difficulty changing a plan or activity when necessary
☐	____	____	Is slow to learn new things
☐	____	____	Difficulty switching from one activity to another activity
☐	____	____	Easily frustrated
☐	____	____	Other problem solving difficulties: _____

2) SPEECH, LANGUAGE, AND MATH SKILLS

√	New	Old	
☐	____	____	Difficulty speaking clearly
☐	____	____	Difficulty finding the right words to say
☐	____	____	Not talking
☐	____	____	Rambles on and on without saying much
☐	____	____	Jumps from topic to topic
☐	____	____	Odd or unusual language or vocal sounds
☐	____	____	Difficulty understanding what others are saying
☐	____	____	Difficulty understanding what he/she is reading
☐	____	____	Difficulty writing letters or words
☐	____	____	Difficulty reading letters or words
☐	____	____	Difficulty with spelling
☐	____	____	Difficulty with math
☐	____	____	Other speech, language, or math problems: _____

3) SPATIAL SKILLS

√	New	Old	
☐	____	____	Confusion telling right from left
☐	____	____	Has difficulty with puzzles, Legos, blocks, or similar games
☐	____	____	Problems drawing or copying
☐	____	____	Doesn't know his/her colors
☐	____	____	Difficulty dressing (not due to physical difficulty)
☐	____	____	Problems finding his/her way around places he/she has been to before
☐	____	____	Difficulty recognizing objects
☐	____	____	Seems unable to recognize facial or body expressions of disapproval or emotions
☐	____	____	Gets lost easily
☐	____	____	Other spatial problems: _____

4) AWARENESS AND CONCENTRATION

√	New	Old	
☐	____	____	Easily distracted by: Sounds____ Sights____ Physical sensations____
☐	____	____	Mind appears to go blank at times
☐	____	____	Loses train of thought
☐	____	____	Difficulty concentrating on what others say, but can sit in front of a TV for long periods
☐	____	____	Attention starts out OK but can't keep it up
☐	____	____	Other attention or concentration problems: _____

5) MEMORY

√	New	Old	
☐	____	____	Forgets where he/she leaves things
☐	____	____	Forgets things that happened recently (e.g. last meal)
☐	____	____	Forgets things that happened days/weeks ago
☐	____	____	Forgets what he/she is supposed to be doing
☐	____	____	Forgets names more than most people do
☐	____	____	Forgets school assignments
☐	____	____	Forgets instructions
☐	____	____	Other memory problems: _____

6) MOTOR AND COORDINATION

√	New	Old		Check the side this occurs on: Right side	Left side	Both sides
☐	____	____	Poor fine motor skills (e.g. using a pencil or crayon)	____	____	____
☐	____	____	Clumsy	____	____	____
☐	____	____	Weakness	____	____	____
☐	____	____	Tremor	____	____	____
☐	____	____	Muscles are tight or spastic	____	____	____
☐	____	____	Odd movements (posturing, peculiar hand movements, etc)	____	____	____
☐	____	____	Drops things more than most children	____	____	____
☐	____	____	Has an usual walk			
☐	____	____	Balance problems			
☐	____	____	Other motor or coordination problems: _____			

7) SENSORY

√	New	Old		Check the side this occurs on: Right side	Left side	Both sides
☐	____	____	Needs to squint or move closer to page to read			
☐	____	____	Problems seeing objects	____	____	____
☐	____	____	Loss of feeling	____	____	____
☐	____	____	Problems hearing sounds			
☐	____	____	Difficulty telling hot from cold			
☐	____	____	Difficulty smelling odors			
☐	____	____	Difficulty tasting food			
☐	____	____	Overly sensitive to: Touch ____ Light ____ Noise ____			
☐	____	____	Other sensory problems: _____			

8) PHYSICAL

√	New	Old		How Often?
☐	____	____	Frequently complains of headaches or nausea	_____
☐	____	____	Has dizzy spells	_____
☐	____	____	Has pains in joints Where? _____	
☐	____	____	Excessive tiredness	
☐	____	____	Frequent urination or drinking	
☐	____	____	Other physical problems: _____	

9) BEHAVIOR

√	New	Old		√	New	Old	
☐	____	____	Aggressive	☐	____	____	Nervous
☐	____	____	Attached to things, not people	☐	____	____	Nightmares, night terrors, sleepwalks
☐	____	____	Bedwetting	☐	____	____	Quiet
☐	____	____	Bizarre behavior	☐	____	____	Resists change
☐	____	____	Bowel movements in underwear	☐	____	____	Risk-taking
☐	____	____	Dependent	☐	____	____	Self-mutilates
☐	____	____	Depressed	☐	____	____	Self-stimulates
☐	____	____	Eating habits are poor	☐	____	____	Shy and withdrawn
☐	____	____	Emotional	☐	____	____	Sleeping habits are poor
☐	____	____	Fearful	☐	____	____	Swears a lot
☐	____	____	Immature	☐	____	____	Unmotivated
☐	____	____	Other unusual behavior: _____				

Below, check all the descriptions of the child that have been present for at least the past 6 months. These behaviors should occur more frequently than in other children of the same age:

____ Is very fidgety
____ Can't remain seated
____ Highly distractible
____ Can't wait for his/her turn when playing with others
____ Answers before he/she hears the whole question
____ Rarely follows others' instructions
____ Has a hard time concentrating for long periods
____ Goes from one activity to another without finishing Anything
____ Frequently makes noise when playing
____ Seems like he/she is always talking
____ Is often rude or interrupts others
____ Doesn't listen to other people
____ Seems like he/she frequently is losing things that are needed for school
____ Frequently does dangerous things without considering the consequences

____ Steals things without people knowing on several occasions
____ Often f\runs away from his parents' home and stays away overnight
____ Easily lies to others
____ Firesetting
____ Doesn't go to school
____ Breaks into other people's property
____ Destroys other people's property in some manner other than by fire
____ Is cruel to animals
____ Has forceable sexual relations with others
____ When fighting, has used a weapon on more than one occasion
____ Starts fights with others
____ Will steal directly from people
____ Is cruel to other people

10) Overall, the child's symptoms have developed: ___ Slowly ___ Quickly

11) The symptoms occur: ___ Occasionally ___ Often

12) Over the past 6 months the symptoms have: ___ Stayed about the same ___ Worsened

PREGNANCY

13) Mother's age at child's birth: _____ Father's age at child's birth: _____

14) **Before** the pregnancy, what medication (prescribed or over-the-counter) did the mother take?
List all medications used: _____

15) **While** pregnant, what medications (prescribed or over-the-counter) did the mother take?
List all medications used: _____

16) How often did the mother see her doctor during the pregnancy?
Regularly (as scheduled by the doctor) ____ Rarely ____ Not at all ____

17) During the pregnancy, which of the following did the mother use?

	Amount and Daily Frequency
____ Alcohol	_____
____ Caffeine (coffee, colas, etc.)	_____
____ Marijuana	_____
____ Recreational drugs (cocaine, heroin, etc.)	_____
____ Tobacco	_____

18) During the pregnancy, the mother's diet was: Good ____ Poor ____
If poor, explain: _____

19) The mother's general physical health during pregnancy was: Good ____ Poor ____
If poor, explain: _____

20) About how much weight did the mother gain while she was pregnant? ____ lbs.

21) During this pregnancy, check all the mother had:
___ Accident
___ Anemia
___ Bleeding (severe or frequent spotting)
___ Diabetes
___ High blood pressure
___ Illnesses or infections
___ Preeclampsia, eclampsia, or toxemia
___ Psychological problems
___ Surgery
___ Vomiting (severe or frequent)

22) How many pregnancies did the mother have prior to this one?
Number of live births: _____
Number of miscarriages: _____

BIRTH

23) Was this child born:
Early ___ How early? _____weeks
On time ___ (38-42 weeks)
Late ___ How late? _____weeks

24) How much did the baby weigh at birth? _____ lbs. _____ oz. OR _____gms.

25) How long did the labor last? _____

26) The labor was: Easy ___ Moderately difficult ___ Very difficult ___

27) What type of medication was the mother given to help with delivery? None ___
Demerol___ Gas___ Regional nerve (spinal) block___ Tranquilizer___ Epidural___

28) Were forceps used during delivery? Yes___ No___

29) Was the baby born:
Head first ___ Transverse (crosswise) ___ Posterior first ___
Breech birth ___ Caesarean section ___ Vacuum extraction ___
Other: _____

30) Did the baby experience any of these problems:
Fetal distress ___ Low placenta (Placenta previa)___ Prolapsed cord ___
Premature separation of placenta (Abruptio placenta) ___ Cord wrapped around neck ___

31) Describe any other special problems the mother or child had during delivery:
_____

32) At birth, did the baby:
Have difficulty breathing? Yes___ No___
Fail to cry? Yes___ No___
Appear inactive? Yes___ No___

33) List the baby's Apgar scores: 1st____ 2nd____

34) If the father or mother noticed anything unusual when they first saw the baby, describe:
_____

35) If the baby was born with any problems (congenital defects, large or small head, blue baby, bleeding in brain, etc.), describe: _____

36) Describe any special care, treatment, or equipment the child was given after birth:
_____

37) Describe any special care, treatment, or equipment the child was given after birth:
_____

38) How long did the baby stay in the hospital? _____

DEVELOPMENTAL HISTORY

39) For each area, indicate the child's development by circling one description. The "Average" period is only a rough idea of what is average since every developmental milestone actually involves a range of several months (e.g., walking occurs approximately 9-18 months of age). Circle "Early" or "Late" only if you are sure the child's development was different from that of most other children.

GROSS MOTOR SKILLS			
Crawled	Early	Average (6-9 months)	Late
Walked alone (2-3 steps)	Early	Average (9-18 months)	Late
LANGUAGE			
Followed simple commands	Early	Average (12-18 months)	Late
Used single-word sentences	Early	Average (12-24 months)	Late
SELF-HELP			
Toilet trained	Early	Average (13-36 months)	Late

40) List any other significant developmental problems:

_____

41) Overall, the child's development was:
Early___ Average___ Late___

42) As an infant or toddler, did the child have poor muscle control (i.e., weakness) of the:
Neck___ Trunk___ Legs___ Arms___

43) As an infant or toddler, did the child's muscles seem to be unusually tight or stiff?
Yes___ No___ If yes, describe: _____

44) Toilet training was:
Easy ____
Difficult ____

45) As an infant or toddler, the child was:
Too calm and inactive ___
Calm and reasonably active___
Irritable and very active ___

46) As a toddler, the child was:
Shy and inhibited ___
Neither shy nor outgoing ___
Very outgoing and liked people ___

HEALTH HISTORY

47) Did the child have a poor appetite as a baby? Yes___ No___

48) Did the child fail to gain weight steadily as a baby? Yes___ No___

49) List the baby's illnesses or physical problems during the first year:

_____

50) Has the child had a temperature of 104°F (40°C) or higher for more than a few hours?
Yes___ No___ If yes, what age(s)?_____ and how long did it last?_____

51) Has the child ever been hit hard on the head or suffered a head injury? Yes___ No___
If yes, what age(s)?_____ Did the child lose consciousness? Yes___ No___
How did it happen?_____
What problems did the child have (physical or mental) afterwards?

_____

52) Has the child been diagnosed with seizures or epilepsy? Yes___ No___
If yes, which type Partial seizure___ Generalized seizure___ Unclassified type___
If medication is used, what medication(s)? _____
Has the child ever had a bad reaction to this medication? Yes___ No___
If yes, describe: _____
Did the child ever have a seizure due to a fever or unknown cause? Yes___ No___
If yes, describe (age, nature of seizure): _____

53) Was the child ever in the hospital for an accident, injury, or operation? Yes___ No___
If yes, what age (s)?_____ What happened? _____

54) Has the child ever swallowed any poison, non-food, or drug accidently? Yes___ No___
If yes, what age (s)?_____ What happened? _____

55) Did the child have frequent ear infections? Yes___ No___
If yes, what age(s)? _____ How often and severe? _____
What treatment was provided? _____

56) Please check all the following diseases or conditions the child has ever had:

___ Allergies	___ Cerebral palsy	___ Jaundice	___ Mumps
___ Anemia	___ Chicken pox	___ Kidney disorder	___ Oxygen deprivation
___ Asthma	___ Colds (excessive)	___ Leukemia	___ Pneumonia
___ Bleeding disorder	___ Diabetes	___ Liver disorder	___ Rheumatic fever
___ Blood disorder	___ Encephalitis	___ Lung disorder	___ Scarlet fever
___ Brain disorder	___ Enzyme deficiency	___ Measles	___ Tuberculosis
___ Broken bones	___ Genetic disorder	___ Meningitis	___ Venereal disease
___ Cancer	___ Heart disorder	___ Metabolic disorder	___ Whooping cough

___ Other problems: _____

57) As the child has been growing up, he/she has been sick:
Much of the time____ An average amount____ Not much at all____

58) List all the medications the child takes now:

Medication	Dosage	How often?	What for?

59) Does the child:
Wear glasses? Yes___ No___ (Farsighted____ Nearsighted____ Other____)
Use a hearing aid? Yes___ No___

60) Within the past year, has the child had: **Results**
A vision test? Yes___ No___ _____
A hearing test? Yes___ No___ _____

61) What is the child's: height _____ft _____in weight ____lbs.

62) When was the child's last medical check-up? _____

63) What therapies have been provided to the child? _____ No therapies
___ Occupational therapy
___ Physical therapy
___ Psychological therapy, counseling, or cognitive rehabilitation
___ Speech therapy
___ Other therapy: _____

FAMILY HISTORY

64) The child lives with:
___ Biological parent(s) only ___ Relatives ___ Foster parents
___ Biological parent and other ___ Adoptive parents ___ Institutional care
___ Other placement _____

65) The family's income is:
under $10,000___ $10,000-$29,000___ $30,000-$50,000___ over $50,000 ___

66) What is the name of the child's biological mother? _____
a. Is she living? Yes___ No___ If deceased, explain: _____
b. Her age? _____
c. What is her level of education? _____
d. Her occupation? _____
e. Does she live in the same house as the child? Yes___ No___
f. How often does she see the child? _____
g. How involved is the mother in the child's upbringing? Very___ Somewhat___ Not at all___
h. Did the mother have a learning disability or other problems when she was in school? Yes___ No___
If yes, describe: _____
i. What are the mother's hobbies? _____

67) What is the name of the child's biological father? _____
a. Is he living? Yes___ No___ If deceased, explain: _____
b. His age? _____
c. What is his level of education? _____
d. His occupation? _____
e. Does he live in the same house as the child? Yes___ No___
f. How often does he see the child? _____
g. How involved is the father in the child's upbringing? Very___ Somewhat___ Not at all___
h. Did the father have a learning disability or other problems when he was in school? Yes___ No___
If yes, describe: _____
i. What are the father's hobbies? _____

68) Please list the names, ages, and grade (or job) of the child's brothers and sisters:

Name	Age	Grade or job

69) Has anyone in the child's biological family (including parents, grandparents, siblings, aunts & uncles) ever had any of the following:

	Which relative?	Describe the problem briefly
___ Brain disease		
___ Developmental delay		
___ Epilepsy or seizures		
___ Learning disability		
___ Mental retardation		
___ Neurologic disease		
___ Psychological problems		
___ Reading or spelling difficulties		
___ Speech or language problems		

70) Which of the child's biological relatives are left-handed?
Mother ____ Father ____ Sibling(s) ____ Grandparent(s) ____ No one ____

71) What languages are spoken in the home? (List in order of the most frequent first.)
(1) _____ (2) _____

72) How is the child disciplined? _____

73) List the child's usual recreational activities and hobbies:
_____

74) Have there been any major family stresses or changes in the past year (e.g., moving with change of school, divorce, significant illness, etc.)? Yes ____ No ____
If yes, explain: _____
How much stress have these changes caused the child? (circle one)
None Mild Moderate Severe

SCHOOL HISTORY

75) The child's present school is: Name _____
Address _____
Phone _____ Contact person _____

76) Was the child ever held back to repeat a grade? Yes _____ No _____
If yes, which grade? _____ Why? _____

77) Has the child ever been in a special class or provided with special services (e.g. resource room, EMR, learning disability class, etc.)? Yes _____ No _____
If yes, describe the special class: _____
Is the child in this class or receiving special services now? Yes _____ No _____

78) Does the child:
Have problems with other children in class? Yes _____ No _____
Have problems making friends in school? Yes _____ No _____
Have problems getting along with teachers? Yes _____ No _____
Tend to get sick in the morning before school? Yes _____ No _____

80) Describe the teacher's concerns about the child's schoolwork or behavior:
_____
_____

81) What kind of grades has the child received in the past year?
A's & B's___ B's & C's___ C's & D's___ D's & F's___
or
Outstanding___ Good___ Satisfactory___ Improvement needed___ Unsatisfactory___
or
Other grading system: _____
Are these grades a change from previous years? Yes _____ No _____

82) In which subject(s) does the child do best? _____

83) Which subject(s) are the most difficult? _____

84) In the past year, how much school has the child missed due to illness or injury?
Less than 2 weeks ___ 2 to 4 weeks ___ 5 to 8 weeks ___ Over 8 weeks ___
Briefly describe the reasons if the child has missed a lot of school:
_____

85) Does the child seem to have a "school phobia"? Yes _____ No _____
If yes, explain: _____

PREVIOUS EVALUATIONS

86) Which of these tests or procedures recently have been done? Note any abnormal findings.

Evaluation	Check here If normal	Abnormal Findings
___ Blood work	_____	_____
___ Family physician or pediatrician office visit	_____	_____
___ Hearing testing	_____	_____
___ Lead level check	_____	_____
___ Lumbar puncture or spinal tap	_____	_____
___ Neurological examination or testing (CT scan, EEG)	_____	_____
___ Psychological or neuropsychological testing	_____	_____
___ School testing	_____	_____
___ Speech & language testing	_____	_____
___ Vision testing	_____	_____
___ X-rays	_____	_____
___ Other tests:	_____	_____
_____	_____	_____
_____	_____	_____

87) What are the names of the physician, psychologist, school authority, or other professions we may contact who are most familiar with the child's problems?

Name _____

Address _____

_____

Phone _____

Profession _____

Name _____

Address _____

_____

Phone _____

Profession _____

_____ _____

Parent or Guardian's Signature Date

THANK YOU FOR TAKING THE TIME TO CAREFULLY COMPLETE THIS QUESTIONNAIRE