

For your child's upcoming appointment at Presbyterian Medical Services, we need your help to provide the best care during the evaluation. Please complete this form, to the best of your ability, prior to your appointment. You may return the form to the clinic by mail or in person. If you do not provide the completed form by the time of the appointment, we may need to reschedule.

In addition, at the time of the appointment, a legal guardian must be present with the child, and no other children may be present. Thank you for trusting PMS to provide your care.

CHILD & FAMILY INFORMATION

Child's full name _____ Grade _____ Age _____ DOB _____
 Current Address: _____ How long at this address? _____
 Person providing this information: _____ Relationship to child _____
 Briefly describe your concerns for your child.

Is your child your: ☐ biological child ☐ adopted child ☐ foster child ☐ other: _____
 Who does child live with: ☐ both parents ☐ mother ☐ father ☐ other (specify) _____
 Biological father _____ Occupation _____ Years education: _____
 Biological mother _____ Occupation _____ Years education: _____
☐ N/A Or: Guardian's name* _____ Occupation _____ Years education: _____

Please list all others who live in household:

Name	Relationship to child/family	How long living in household?

Language(s) spoken at home _____ Primary Language at home _____
 Are biological parents of child currently: ☐ married ☐ separated ☐ divorced ☐ never married
 • If separated or divorced, who has *legal* custody*? ☐ mother ☐ father ☐ other (specify): _____

• If separated or divorced, how do you feel your child has adjusted to separation/divorce? _____

*Please be sure to provide legal documentation to the clinic regarding guardianship, custody, and medical decision-making authority.

Are there other adults who have a *significant* part in raising your child? ☐ Yes ☐ No

If so, please indicate name & relationship (step-parent, grandparent, etc.) _____

Have there been any significant changes in the home over the last few years? (such as new marriages, deaths, births, address changes, family separation/divorce, parent dating, money problems, etc.) _____

HEALTH AND DEVELOPMENT

Mother's age at birth? _____ Did mother receive routine medical prenatal care? ☐ Yes ☐ No

Please specify any medications used during pregnancy and the reason used: _____

Pregnancy lasted _____ weeks/ months Child's birth weight: _____ pounds _____ ounces

Please check the conditions below that describe the health of the child and mother during...

Mother's Pregnancy

- ☐ No Complications
- ☐ Blackouts
- ☐ Falls
- ☐ Physical Injury
- ☐ Excessive Bleeding
- ☐ Hypertension
- ☐ Diabetes
- ☐ Emotional Stress
- ☐ Toxemia
- ☐ Alcohol/ Drug Use
- ☐ Use of Tobacco

Child's Delivery

- ☐ Normal
- ☐ Induced Labor
- ☐ C-Section
- ☐ Breech birth
- ☐ Unusually long labor (>12hrs)
- ☐ Premature, # of weeks _____
- ☐ Overdue, # of weeks _____
- ☐ Other Problem (Specify) _____

Child's Condition at Birth

- ☐ Normal/ No problems
- ☐ Lack of Oxygen
- ☐ Breathing Problems
- ☐ Birth Injury/ Defect
- ☐ Jaundice
- ☐ Newborn ICU # of days _____
- ☐ Other Problem (Specify) _____

Describe the state of your child's current health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of child's primary care provider: _____ Phone: _____

Is your child currently taking any medication? ☐ Yes ☐ No

If yes, please list medications and uses: _____

Has your child ever been identified as having a disability? ☐ Yes ☐ No

If so, by whom, what age, & what disability? _____

Has your child ever received counseling? ☐ Yes ☐ No

If yes, by whom (professional/ agency) and when: _____

Has your child had any of the following?	Please describe and give details, dates, and/or age of onset
☐ Serious Bodily Injuries	
☐ Head Injuries	
☐ Surgery/ Hospitalization	
☐ Been diagnosed with seizures or convulsions	
☐ Other health problem:	

Is there a family history of the following?	Biological family member with the history...
☐ Learning Difficulties (reading, math, writing)	
☐ Speech or Language problem (stuttering, etc.)	
☐ Developmental Disorder (such as Autism, etc.)	
☐ Emotional Problems (depression, mood swings, etc.)	
☐ Mental Retardation	
☐ School Failure (failing grades, dropout, etc.)	
☐ Drug or Alcohol Addiction	

Please indicate the age when your child performed the following milestones:

Milestone:	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years
Crawled							
Walked							
Spoke first words							
Fully potty trained							

EARLY BEHAVIOR

During your child's first few years of life, were any of the following significantly present?

- | | |
|---|---|
| ☐ Was not easily calmed by being held or stroked | ☐ Difficult nursing |
| ☐ Colicky/Irritable | ☐ Poor eye contact |
| ☐ Poor sleep | ☐ Did not respond to their name |
| ☐ Hyperactive | ☐ Fascination with certain objects |
| ☐ Difficulty with change/ transitions | ☐ Constantly head banging |
| ☐ Irregular patterns of sleep, appetite etc. | ☐ Difficulty Maintaining focus/concentration |

If you checked any of the above, please describe _____

CURRENT BEHAVIOR

Please check below all behaviors or characteristics that fit your child over the past year:

- | | |
|--|--|
| ☐ Destructive behavior | ☐ Appears depressed & unhappy much of the time |
| ☐ Is affectionate with family & friends | ☐ Explosive temperament |
| ☐ Responds well to authority figures | ☐ Frequently complains about aches and pains |
| ☐ Boundless energy and poor judgement | ☐ Appears to have low self-esteem |
| ☐ Known to harm animals or smaller children | ☐ Prefers to be alone (or considers self "a loner") |
| ☐ Disorganized, loses things often | ☐ Starts fires |
| ☐ Shows sudden physical aggression | ☐ Lacks motivation |
| ☐ Frustrated easily | ☐ Steals or lies |
| ☐ Shifts from one activity to another | ☐ Becomes upset with change |
| ☐ Has difficulty playing quietly | ☐ Fearfulness |

- | | |
|--|--|
| ☐ Requires a lot of parent attention | ☐ Frequent peer and/or family conflicts |
| ☐ Fidgets a lot | ☐ Does not appear to listen to what is being said |
| ☐ Appears to daydream or “zone out” often | ☐ Always worrying about something |
| | ☐ Nervous habits (nail biting, hair twirling, etc.) |

Which adult would your child prefer to talk with about a problem? _____

Who is the family member that your child feels closest to? _____

How is discipline administered in the home and has it been successful? _____

Indicate your child’s Bed time? ____:____ Wake time? ____:____ Do they sleep well? _____

How much time does your child typically spend on electronic media?

Watching TV or other Video: ____hrs./day Playing video/computer games: ____ hrs./day

Other: _____

How would you describe your child’s peer relationships and choice of friends? (i.e. How many friends? What age/genders? Is child shy, outgoing, a leader, a follower, etc.?) _____

EDUCATIONAL HISTORY

Does your child try to avoid going to school? _____

How motivated do you feel your child is to learn? _____

How much of a struggle is homework? ☐ Not a struggle ☐ Sometimes a struggle ☐ Often a struggle

Does your child receive special school services? ☐ Yes ☐ No

If yes, which program and when services began _____

Was formal testing completed to determine special educational needs? ☐ Yes ☐ No

If yes, when and where? _____

PLEASE BRING A COPY OF SCHOOL TESTING/IEP RESULTS TO EVALUATION VISIT