



Welcome to our office! We are very pleased to be able to offer psychoeducational testing services. Our responsibility lies in administering the needed assessments in order to address our patient's academic and/or behavioral needs. Enclosed you will find additional forms that will aid us in assisting you more effectively. Our professional staff will be glad to discuss with you our services, charges, insurance billing, appointments, as well as any other questions you may have.

If you cannot attend a scheduled appointment, kindly notify us as soon as possible. **Please be aware that you will be charged the full and agreed upon \$150 fee for any appointment that is not cancelled twenty-four (24) hours in advance.** You will be solely responsible for this charge as we cannot bill an insurance company for a service not provided.

Confidentiality is of primary importance in mental health practice. Consequently, we adhere to very strict standards regarding the release of records and/or information related to you or your family for your own protection. All communication between us is confidential and privileged, with the following three exceptions:

1. In staff supervision and with consultants, as needed, in order to challenge and/or confirm decisions about diagnosis, treatment, and medication.
2. Should you choose to use insurance to cover the cost of therapy, detailed treatment reports are frequently required by the managed care companies on a regular basis in order to access benefits and determine medical necessity.
3. By statutory law, "DUTY TO WARN" outweighs the limits of confidentiality and privilege in case of a reported act, which may endanger yourself or others.

Finally, good communication is essential for successful delivery of services. Please feel free to share with us any of your suggestions or concerns.

INFORMED CONSENT AND AUTHORIZATION FOR SERVICES

I understand that I am requesting a private psychoeducational evaluation to be performed at my own expense by Cristina M. Olachea, Ed.S., Licensed School Psychologist.

I am fully aware that some or all of the requested services may be available to me at no cost through the public school system.

I understand that a number of factors need to be considered in order for any evaluation to lead to appropriate educational programming. Such factors may include, but are not limited to, the following:

- While a school district must consider the results of a private evaluation, they are not required to accept the results and recommendations for eligibility decisions.
- The results of certain tests may not be valid if retesting occurs more frequently than recommended by test publishers.
- In order for tests to be utilized for eligibility determination, selected test instruments must be consistent with the local school district's procedures.

My signature below indicates that I am entering into this professional relationship freely and voluntarily, with full knowledge of the implications of the agreement. I have read and agree with the terms stated herein. Thus, I hereby consent to psychoeducational testing services.

Patient Name (Please print)

X _____
Cristina M. Olachea, Ed.S.
Licensed School Psychologist
SS-966

X _____
Patient or Parent/Guardian Signature

Date

This is a strictly confidential patient medical record.



Patient's Name: _____ Date of Birth: _____

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I, _____ (patient/patient's guardian), authorize a mutual exchange of information about the above mentioned patient between the Licensed School Psychologist at Coral Gables Counseling Center, Cristina M. Olaechea Ed.S., and the following recipient:

Name:

Address:

Phone:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This information includes, and is not limited to, medical records, therapy notes/reports, academic records, counseling information, and other pertinent information used solely for the facilitation of services rendered to the above-named individual.

If we are requesting this authorization from you for your own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- We may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this authorization; and
- We must provide you with a copy of this authorization.

You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization.

Unless revoked earlier or otherwise indicated, this authorization will expire in 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under federal law.

Signed: _____ Date: _____
(Patient or Patient's Guardian)

Representative's relationship to Guardian: _____

INSURANCE / BILLING INFORMATION

(IF APPLICABLE)

PLEASE HAVE AVAILABLE YOUR INSURANCE CARD IN ORDER FOR US TO PHOTOCOPY

PATIENT NAME: _____

INSURANCE CO. NAME: _____ ID: _____

INSURED/SUBSCRIBER NAME: _____ D.O.B. _____

SS#: _____ EMPLOYER: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMAIL ADDRESS: _____

PRIOR AUTHORIZATION NUMBER if applicable (EAP cases, for example): _____

INSURANCE CONSENT

Your insurance benefits may be limited by the number of visits/hours granted per calendar year or by the total dollar amount available. Furthermore, your insurance company may impose limits on the number of visits you receive based on their definition of medical necessity.

When we accept assignment of insurance benefits for payment of your bill we are in effect acting as the insurance company's agent or provider. It is also important for you to understand that when you sign an authorization to release information on your insurance form, we may be asked to discuss, in a verbal or written report, information related to your case with a case manager. A case manager is a clinical representative of the insurance company and will not reveal information to your employer. This contact may be necessary to facilitate continuing payment for services.

I understand and have discussed the above conditions. I am ready to accept services under these conditions.

X _____
Patient or Parent/Guardian Signature Patient or Parent/Guardian Printed Name Date

SIGNATURE ON FILE AND ASSIGNMENT OF BENEFITS AGREEMENT

I understand that Coral Gables Counseling Center will use my signature below as a *signature on file*. I authorize the release of any medical information necessary to process my (or my family member's) claim or related claims.

I hereby authorize payment directly to the Coral Gables Counseling Center of the insurance benefits otherwise payable to me for their professional services. I understand that I am financially responsible to the Coral Gables Counseling Center for all charges not covered by this assignment.

X _____
Patient or Parent/Guardian Signature Patient or Parent/Guardian Printed Name Date

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FINANCIAL AGREEMENT

I, _____, agree that the responsibility for the hourly charge of \$ _____ and/or full psychoeducational testing fee of \$ _____ at the Coral Gables Counseling Center is mine. I understand that half of the testing fee is to be paid on the first day of testing and that the remaining balance will be paid upon the receipt of the written report at the feedback session.

I agree to assign to the Coral Gables Counseling Center any insurance benefits available to me. However, should said insurance not provide for the expected coverage, I am fully responsible for the full agreed upon fee. I also understand that if I have not paid my balance within 60 days, Coral Gables Counseling Center will turn my account over to an outside collection agency without further notice. I agree to be responsible for any additional collection fees that may occur in this event.

I understand and have discussed the above conditions. I am willing to accept services under these conditions.

X _____
Patient or Parent/Guardian Signature Patient or Parent/Guardian Printed Name Date

ELECTRONIC PAYMENT AUTHORIZATION

In an effort to avoid difficulties with your account, please provide credit/debit card information on the space below. This information will only be used in processing payments due to one or more of the following: testing/hourly rate balance, returned bank checks, other declined credit cards, missed or late cancelled appointments (\$150 fee), denial of expected coverage by insurance companies, and phone/Skype sessions.

Please rest assured that we will make every effort to discuss your account before using this avenue to bring your balance up to date. Thank you for your cooperation.

CREDIT CARD TYPE MASTERCARD VISA AMEX DISCOVER

CARD NUMBER _____ - _____ - _____ - _____

EXP. DATE: ____ / ____ CVV: _____ ZIP: _____

Please indicate the name and address associated with the credit or debit card you wish to use.

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

I agree to allow Coral Gables Counseling Center to charge my credit card above for the amount of \$ _____ per hour or the full testing fee of \$ _____ until this authorization expires on _____.

X _____
Cardholder Signature Cardholder Printed Name Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our signatures below acknowledge that we have reviewed and discussed the “Notice of Privacy Practices” attached to the intake packet and, if requested, acknowledge that the patient and/or the patient’s legal guardian(s) has/have received a copy of the document.

I have read this document and have been given the opportunity to ask any questions and receive any clarification.

Patient Name (Please Print)

Date

X _____
Patient or Legal Guardian Signature

Printed Name of Legal Guardian,
if applicable

X _____
Cristina M. Olachea, Ed.S.
Licensed School Psychologist
SS-966

Date

_____ **Copy accepted by PATIENT/LEGAL GUARDIAN**

_____ **Copy kept by School Psychologist** *You may request a copy at a later time*

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INTAKE INFORMATION

*Thank you for taking the time to carefully complete this questionnaire
and help us get to know you better!*

Date: _____

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____

Gender: _____ Age: _____ Date of Birth: _____ School: _____ Grade: _____

Marital Status (If Applicable): Married Single Divorced Separated Widowed Living with significant other

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Other: _____ May we leave a message? YES / NO What is the contact method you prefer? _____

Email: _____ SS#: _____

Employer Name: _____ Position: _____

Address: _____ Phone: _____ Ext: _____

City: _____ State: _____ Zip: _____ May we contact you at work? YES / NO

We'd love to keep you informed of any upcoming events, community resources and workshops, as well as exclusive articles from our skilled clinicians. May we add you to our CGCC email database?

Yes! No, thank you.

Please tell us your reason for seeking psychoeducational testing: _____

Who referred you to us? _____

I. PRESENTING PROBLEM

Please check all that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Hitting | <input type="checkbox"/> Self-stimulatory behaviors:
rocking, spinning, flapping
hands, visual scrutiny |
| <input type="checkbox"/> Peer relationships | <input type="checkbox"/> Self-injury | <input type="checkbox"/> Muscle tone |
| <input type="checkbox"/> School environment | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Sensory regulation |
| <input type="checkbox"/> Over-activity | <input type="checkbox"/> Appetite/food selections | <input type="checkbox"/> Following directions |
| <input type="checkbox"/> Language abilities | <input type="checkbox"/> Inattentive | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Toilet training | <input type="checkbox"/> Self-help skills | |
| <input type="checkbox"/> Preoccupations | <input type="checkbox"/> Motor skills | |
| <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Depressed or anxious | |
| <input type="checkbox"/> Biting | <input type="checkbox"/> Medication | |

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II. EARLY CHILDHOOD HISTORY

Pregnancy

Did the biological mother have any of the following immediately before, during, or after pregnancy?

- Maternal injury. Describe: _____
- Hospitalization during pregnancy. Reason: _____

Did the biological mother experience any of the following during pregnancy?

- | | | |
|--|--|---|
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Vaginal bleeding | <input type="checkbox"/> Severe cold |
| <input type="checkbox"/> Infections | <input type="checkbox"/> Measles/German measles | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Premature Labor | <input type="checkbox"/> Excessive nausea/vomiting | <input type="checkbox"/> Airplane trip during pregnancy |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Flu | <input type="checkbox"/> Gestational diabetes |
| <input type="checkbox"/> Bedrest | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Separation |
| <input type="checkbox"/> Toxemia | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Divorce/loss |
| <input type="checkbox"/> Difficulty in conception | <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Meds: _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Threatened miscarriage | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Gained more than 35 pounds | <input type="checkbox"/> Rh incompatibility | |
| <input type="checkbox"/> Excessive swelling | <input type="checkbox"/> Headaches | |
| <input type="checkbox"/> Special diet, describe: _____ | | |

Mother's age at conception: _____ Father's age at conception: _____

Maternal tobacco, alcohol, and/or drug use history while pregnant? _____

Did mother receive prenatal care during this pregnancy? No Yes, beginning at month _____

During the pregnancy, was the baby: Very active Average Rather quiet

Delivery

Place of birth: _____ Birth weight: _____ Length: _____

Was infant born full-term? Yes No If premature, how early? _____ If overdue, how late? _____

Check all of the following that applied to the delivery:

- | | | |
|---|--|---|
| <input type="checkbox"/> Breech | <input type="checkbox"/> Head first | <input type="checkbox"/> Cord around neck |
| <input type="checkbox"/> Forceps | <input type="checkbox"/> Multiple births | <input type="checkbox"/> Spontaneous |
| <input type="checkbox"/> Induced; Reason: _____ <input type="checkbox"/> Caesarean; Reason: _____ | | |

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Which of the following applied to the infant? (check all that apply)

- Breathing problems
- Jaundice (Were Bilirubin lights used? _____ For how long? _____)
- Feeding problems
- Sleeping problems
- Infection
- Rash
- Required oxygen
- Excessive crying
- Sleeping problems
- Seizures/convulsions
- Bleeding into the brain
- Required incubator
- Unusual appearance, describe: _____

Did the infant require: X-Rays CT scans Blood transfusions
 Placement in the NICU (If so, for how long? _____)

Length of stay in hospital: Mother _____ Infant _____

Developmental History

During this child’s first three years, were any special problems noted in the following areas?

- Irritability
- Breathing problems
- Colic
- Reflux
- Difficulty sleeping
- Eating problems
- Temper tantrums
- Failure to thrive
- Excessive crying
- Withdrawn behavior
- Poor eye contact
- Early learning problems
- Destructive behavior
- Convulsions/Seizures
- Twitching
- Unable to separate from parent
- Other _____

Please indicate age when child completed the following developmental milestones:

_____ sat unaided _____ fed self with spoon _____ bowel trained
 _____ crawled _____ bladder trained –day
 _____ walked _____ bladder trained –night

Can child be described as: Clumsy/uncoordinated? Yes No
 Having fine motor delay? Yes No

Current eating behavior: Normal Picky Eats too much Weight loss/gain
 Current sleeping behavior: Normal Problematic Difficult
 Oral Motor concerns: None Difficulty swallowing Drooling Gagging



Indicate age when: child began babbling, such as repeating syllables, in attempts to communicate? _____
using single words? _____ using phrases/short sentences? _____

Have there been any *hearing* concerns? No Yes Date of last hearing test: _____

Have there been any *vision* concerns? No Yes Date of last vision test: _____

Does patient wear eyeglasses? YES / NO Hearing aids? YES / NO

List child's recreational activities and hobbies: _____

Checklist: Please mark any of the following in each area that describe your child currently or in the past:

Speech

Past Current

Past Current

- slow speech development doesn't understand without gestures
- unusual tone or pitch repeats words/phrases over and over again
- difficult to understand speech repeats questions, instead of answering them
- seldom speaks unless prompted repeats dialogue from movies or songs verbatim
- has language of his/her own (may sound like foreign language/jargon)

Relating with other people

Past Current

Past Current

- prefers to be by self "in a world of his/her own"
- aloof, distant clings to people
- fearful of strangers not cuddly as baby
- doesn't like to be held doesn't recognize parent
- doesn't play with other children prefers playing with younger or older children

Imitation

Past Current

- doesn't imitate waving "bye-bye" or "patty cake" etc. (physical imitation)
- doesn't repeat words/things said to him/her
- doesn't repeat words generally, but usually did what he was asked to do

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Response to Sounds, Speech

Past Current

- often ignores sounds
- afraid of certain sounds
- seems to hear distant or soft sounds that most other people don't hear or notice
- unpredictable response to sounds (sometimes reacts, sometimes doesn't)
- responds to speech and sounds like other children of the same age

Past Current

- often ignores what is said to him/her (speech)
- really likes certain sounds (music, motors, etc.)

Visual Response

Past Current

- stares vacantly around room
- often doesn't look at things
- likes to look at self in mirror
- likes to look at shiny objects
- stares at parts of his/her body (e.g. hands)
- often avoids looking at people when they are talking to him/her

Past Current

- plays with turning lights on and off
- distracted by lights – stares at certain lights
- very interested in small parts of an object
- looks at things out of the corners of eyes

Other Senses

Past Current

- puts many objects in mouth
- licks objects
- overreacts to pain
- chews or eats objects that are not supposed to be eaten

Past Current

- likes vibrations
- doesn't notice pain as much as most people
- smells unusual objects or unfamiliar objects

Emotional Responses

Past Current

- temper tantrums
- overly responds to situations
- cries/seems sad for no obvious reason
- little response to what is happening around him/her

Past Current

- laughs/smiles for no obvious reason
- moods change quickly/for no apparent reason
- often has blank expression on face

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III. MEDICAL HISTORY

Has your child ever had:

- Head injury: Age _____ Describe _____
- Loss of consciousness: Age ____ How long? _____ Describe _____
- Allergies to food/medication: List: _____
- Special diets: Describe: _____
- Hospitalizations: Age _____ Reason _____ Describe _____
- Surgery: Age _____ Reason _____ Describe _____
- Ear Infections: Age ____ Describe _____

Is the child up to date on immunizations? Yes No, Why not? _____

Patient tobacco, alcohol, and/or drug use history, if applicable: _____

Doctors seen (check all that apply)

- Pediatrician – Name _____ Date of last visit: _____ Diagnosis: _____
- Dev. Pediatrician – Name _____ Date of last visit: _____ Diagnosis: _____
- Neurologist – Name _____ Date of last visit: _____ Diagnosis: _____
 - suspected seizures, describe: _____
 - seizures diagnosed, type: _____
- Genetics – Name _____ Date of last visit: _____ Diagnosis: _____
- Psychiatrist – Name _____ Date of last visit: _____ Diagnosis: _____
- Gastroenterologist – Name _____ Date of last visit: _____ Diagnosis: _____
 - stomach/intestinal problems, type: _____
- Endocrinologist – Name _____ Date of last visit: _____ Diagnosis: _____

Diagnostic Testing (check all that apply)

- EEG (brain wave test) – Date: _____ Results: _____
- MRI – Date: _____ Results: _____
- CT Scan – Date: _____ Results: _____

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- Ophthalmology Evaluation – Date: _____ Results: _____
- Chromosomal/DNA testing (Genetic) – Date: _____ Results: _____
- Other - Describe: _____

Medication history

Please indicate CURRENT medications patient is taking:

Name of medication	Dose & Frequency	Date Started	Reason	Effectiveness

Who prescribes these medications? _____ Date of last visit: _____

Please also list any medications your child has been on in the PAST:

Name of medication	Dose & Frequency	Date Started & Ended	Reason	Effectiveness

Who prescribed past medications? _____

Does patient take any over the counter medications or supplements? Please describe: _____

IV. FAMILY HISTORY

With whom does the child currently reside? (please mark all that apply)

- Biological Mother Biological Father Stepmother Stepfather
- Adoptive Mother Adoptive Father Foster Mother Foster Father
- Other (describe: _____)

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PATIENT INTAKE FORM

Complete the following for the child's BIOLOGICAL PARENTS to the best of your ability, *even if you are not the child's biological parent.*

Biological Mother's Name: _____ Age: _____

Address: _____ Phone: _____ Email: _____

Occupation: _____ Ethnic/Cultural Background: _____

Biological Father's Name: _____ Age: _____

Address: _____ Phone: _____ Email: _____

Occupation: _____ Ethnic/Cultural Background: _____

If the child currently resides with parents OTHER than biological parents, please list them here.

Parent 1 Name: _____ Age: _____

Relationship to child: Adoptive Parent Step-Parent Foster Parent Other: _____

Address: _____ Phone: _____ Email: _____

Occupation: _____ Ethnic/Cultural Background: _____

Parent 2 Name: _____ Age: _____

Relationship to child: Adoptive Parent Step-Parent Foster Parent Other: _____

Address: _____ Phone: _____ Email: _____

Occupation: _____ Ethnic/Cultural Background: _____

Highest level of education by each parent:

Biological Mother	Biological Father	Parent 1 (above, if app.)	Parent 2 (above, if app.)
<input type="checkbox"/> 11 th grade or less	<input type="checkbox"/> 11 th grade or less	<input type="checkbox"/> 11 th grade or less	<input type="checkbox"/> 11 th grade or less
<input type="checkbox"/> GED	<input type="checkbox"/> GED	<input type="checkbox"/> GED	<input type="checkbox"/> GED
<input type="checkbox"/> High school graduate	<input type="checkbox"/> High school graduate	<input type="checkbox"/> High school graduate	<input type="checkbox"/> High school graduate
<input type="checkbox"/> Associate Degree	<input type="checkbox"/> Associate Degree	<input type="checkbox"/> Associate Degree	<input type="checkbox"/> Associate Degree
<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Bachelor's Degree
<input type="checkbox"/> Graduate/Professional	<input type="checkbox"/> Graduate/Professional	<input type="checkbox"/> Graduate/Professional	<input type="checkbox"/> Graduate/Professional
<input type="checkbox"/> Vocational Certificate	<input type="checkbox"/> Vocational Certificate	<input type="checkbox"/> Vocational Certificate	<input type="checkbox"/> Vocational Certificate

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PATIENT INTAKE FORM

If child does not live with BOTH biological parents, who has legal custody of the child? _____

How often does the other biological parent see this child? _____

Number of years married/together: _____ Approximate date of divorce/separation: _____

Number of times married: Mother _____ Father _____

If child is with ADOPTIVE parent, age child was first in home: _____ Date of legal adoption: _____

What has the child been told about the adoption? _____

If your child spends a significant amount of time with a caregiver other than someone described above (i.e., spends more than 4 hours/day) EXCLUDING school personnel, please complete the following information for that person here:

Name: _____ Age: _____

Relationship to child: _____ Ethnic/Cultural Background: _____

Occupation: _____ Highest level of education: _____

Siblings: (please list whether the siblings live in the child's home or not)

Name	Age	Sex	Full/Step/Half?	Grade	In child's home?
------	-----	-----	-----------------	-------	------------------

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Other occupants of child's residence NOT listed above: _____

What languages does the child use (List PRIMARY language first)? _____

What other language is your child exposed to? _____

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Family Changes and Stressors: Please indicate any major family stresses the family and/or child is currently experiencing or has experienced within the last year.

- | | | |
|--|--|--|
| <input type="checkbox"/> Marital discord/fighting | <input type="checkbox"/> Parent/sibling death | <input type="checkbox"/> Physical abuse |
| <input type="checkbox"/> Separation | <input type="checkbox"/> Parent deployed extensively | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Parent emotionally/mentally ill | <input type="checkbox"/> Parental disagreement about child-rearing |
| <input type="checkbox"/> Birth/Adoption of another child | <input type="checkbox"/> Involved in juvenile court | <input type="checkbox"/> Involved with Social Services/Child Protective Services |
| <input type="checkbox"/> Sibling conflict | <input type="checkbox"/> Abandonment by parent | |
| <input type="checkbox"/> Parent-Child conflict | <input type="checkbox"/> Financial problems | |
| <input type="checkbox"/> Custody disagreement | <input type="checkbox"/> Parent substance abuse | |
| <input type="checkbox"/> Single-parent family | <input type="checkbox"/> Child Neglect | Other: _____ |

When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?

- | | | | |
|-----------------------------------|---|--|------------------------------------|
| <input type="checkbox"/> Time Out | <input type="checkbox"/> Loss of allowance/privileges | <input type="checkbox"/> Yelling | <input type="checkbox"/> Grounding |
| <input type="checkbox"/> Ignoring | | <input type="checkbox"/> Physical punishment | |

Who is mainly in charge of discipline? _____

What do you find most difficult about raising your child? _____

Family Medical/Educational History:

Have any members of the biological mother's or biological father's families had any of the following problems or disorders (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Birth defect | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Speech/language delay |
| <input type="checkbox"/> Chromosomal/genetic disorder | <input type="checkbox"/> Huntington's chorea | <input type="checkbox"/> Autism/PDD |
| <input type="checkbox"/> Obsessive compulsive disorder | <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Reading problem |
| <input type="checkbox"/> Severe head injury | <input type="checkbox"/> Sickle-cell anemia | <input type="checkbox"/> Other learning disability |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Emotional disturbance/mental illness |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Bipolar/manic-depressive disorder |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tics/Tourette's syndrome |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Antisocial behavior (assaults, thefts, arrests, etc.) |
| <input type="checkbox"/> Physical handicap | <input type="checkbox"/> Food allergies | <input type="checkbox"/> Childhood behavior disorder (aggressive/defiant/ADHD) |
| <input type="checkbox"/> Nervousness/Anxiety | <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Tuberous sclerosis | <input type="checkbox"/> Physical/Sexual abuse | |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Schizophrenia | |
| | <input type="checkbox"/> Intellectual deficiency | |

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Has anyone in the family ever received special education services? No Yes - for what reason?

V. EDUCATION AND SOCIAL

Current school: _____ School district: _____

Retentions, Suspensions, or Expulsions? _____

Type of class: Regular Special Education Advanced Gifted

Current ratio: Students _____ Teachers _____ Aides _____

Does your child have a 1:1 Aide? _____

Has your child received an evaluation in the past? **(Please bring copy of reports to 1st appointment)**

Psychological/Cognitive – Date: _____ Academic – Date: _____

Speech/Language – Date: _____ Other: _____ Date: _____

Does your child like school? Most of the time Sometimes Almost never

Does your 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

Describe the teacher's current concerns about your child's schoolwork or behavior: _____

What are your child's strengths? _____

What kind of grades has your child received in the past year?

A's & B's B's & C's C's & D's D's & F's

Outstanding Good Satisfactory Improvement needed Unsatisfactory

Other grading system

Are these grades a change from previous years? Yes No

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: _____

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SERVICES

School District

Is your child on an IEP (Individual Education Plan)? Yes No

Child's age when school special education services began: _____

Individual Education Plan (IEP) eligibility: _____

(Please bring copies of your most recent Individual Education Plan (IEP))

Which services is your child CURRENTLY receiving through the SCHOOL DISTRICT?

Speech Therapy Language Therapy Occupational Therapy

Physical Therapy Tutoring Counseling

Other – describe: _____

Please list all of the schools, including preschools, your child has attended:

Name of school	Age/grade attended	Hours per day	Days per week
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Private Services (Please bring copies of relevant reports to your first appointment)

Are you or your insurance currently paying for services to address your child's needs? Yes No

Speech/Language Therapy Provided by: _____ Age when began: _____

Occupational Therapy Provided by: _____ Age when began: _____

Physical Therapy Provided by: _____ Age when began: _____

Adaptive Physical Education Provided by: _____ Age when began: _____

Social Skills Provided by: _____ Age when began: _____

Applied Behavior Analysis (ABA) Provided by: _____ Age when began: _____

Psychological/Counseling Provided by: _____ Age when began: _____

Psychiatric Provided by: _____ Age when began: _____

Tutoring Provided by: _____ Age when began: _____

Other - describe: _____

This is a strictly confidential patient medical record.