CORAL GABLES Counseling CENTER

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. Olaechea, 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.

_____ X_____

Patient Name (Please print)

Cristina M. Olaechea, Ed.S.
Licensed School Psychologist
SS-966

X_____ _____

Patient or Parent/Guardian Signature **Date**

CORAL GABLES Counseling CENTER

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: _____

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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

CORAL GABLES Counseling CENTER

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 the remaining balance is due on the last day of testing.

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. Olaechea, Ed.S. Date
Licensed School Psychologist
SS-966

____ **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:

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

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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?

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

☐ 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:

☐ Breech	☐ Head first	☐ Cord around neck
☐ Forceps	☐ Multiple births	☐ Spontaneous

☐ Induced; Reason: _____ ☐ Caesarean; Reason: _____

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

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

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

Please indicate age when child completed the following developmental milestones:

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

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

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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

Past Current

☐ ☐ often ignores what is said to him/her (speech)

☐ ☐ really likes certain sounds (music, motors, etc.)

☐ ☐ 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

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

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

☐ ☐ stares at parts of his/her body (e.g. hands)

☐ ☐ often avoids looking at people when they are talking to him/her

Other Senses

Past Current

☐ ☐ puts many objects in mouth

☐ ☐ licks objects

☐ ☐ overreacts to pain

Past Current

☐ ☐ likes vibrations

☐ ☐ doesn't notice pain as much as most people

☐ ☐ smells unusual objects or unfamiliar objects

☐ ☐ chews or eats objects that are not supposed to be eaten

Emotional Responses

Past Current

☐ ☐ temper tantrums

☐ ☐ overly responds to situations

☐ ☐ cries/seems sad for no obvious reason

Past Current

☐ ☐ laughs/smiles for no obvious reason

☐ ☐ moods change quickly/for no apparent reason

☐ ☐ often has blank expression on face

☐ ☐ little response to what is happening around him/her

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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: _____

□ 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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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.)
☐ 11th grade or less	☐ 11th grade or less	☐ 11th grade or less	☐ 11th grade or less
☐ GED	☐ GED	☐ GED	☐ GED
☐ High school graduate	☐ High school graduate	☐ High school graduate	☐ High school graduate
☐ Associate Degree	☐ Associate Degree	☐ Associate Degree	☐ Associate Degree
☐ Bachelor's Degree	☐ Bachelor's Degree	☐ Bachelor's Degree	☐ Bachelor's Degree
☐ Graduate/Professional	☐ Graduate/Professional	☐ Graduate/Professional	☐ Graduate/Professional
☐ Vocational Certificate	☐ Vocational Certificate	☐ Vocational Certificate	☐ Vocational Certificate

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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.

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

Other: _____

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

☐ Time Out ☐ Loss of allowance/privileges ☐ Yelling ☐ Grounding ☐ Ignoring ☐ 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):

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

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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: _____