Colorado Center *for*
Assessment & Counseling
KNOWLEDGE *to* THRIVE

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General Information

Date: _____ Child's Date of Birth: _____ Child's Age: _____

Child's Full Name: _____

Address (include zip): _____

Phone: Home: _____ Is it okay to leave a detailed message at this number? Yes __ No __

Cell: _____ Is it okay to leave a detailed message at this number? Yes __ No __

E-Mail Address: _____

Do I have your consent to email an appointment reminder prior to sessions? Yes _____ No _____

Do I have your consent to email digital copies of:

1) Records: Yes _____ No _____

2) Billing statements: Yes _____ No _____

Emergency contact or parent/guardian name: _____

Phone #: _____ Email Address: _____

Please tell me a little more about your child:

Gender: _____

Ethnicity: _____

Spiritual beliefs: _____

Disability (if any): _____

Sexual orientation: _____

School & Grade: _____

Handedness: _____

Who referred you to our service? Please provide contact information: _____

_____

Is this referral a result of or related to any legal or court proceedings? If so please provide name of attorney.

_____

Please list the reason(s) for referral or primary concerns that led you to seek an evaluation at this time:

_____

_____

_____

Developmental/Medical History

Pregnancy and Birth

Pregnancy/Birth/Delivery Complications? Please Describe: _____

_____

_____

Medications used during pregnancy? _____

Yes No Smoking? How much? _____
Yes No Drug Intake? Type? _____ How much? _____
Yes No Alcohol? How much? _____

Length of pregnancy? _____ (weeks) Age of mother at birth: _____
Birth weight: _____ lbs. _____ oz. Birth length: _____ APGAR scores? _____/_____
Type of delivery: _____spontaneous __induced _____caesarean _____with instruments _____ breech

Any complications for mother or infant after birth? Please explain:

Developmental Milestones

Yes No Enjoyed cuddling
Yes No Fussy, irritable
Yes No More active than other babies
Yes No If child has other siblings, was development different in any way? Explain:

At what age did this child first do the following (indicate with year and month of age).
Turn over _____ Crawl _____ Stand Alone _____ Walk Alone _____
Walk Upstairs _____ First Words _____ First Phrases _____

Is child toilet Trained? **Yes No** If yes, Days? _____ Nights?_____
Did bed wetting or soiling occur after training? **Wetting Soiling** If yes, until what age? _____

Does your child have any speech difficulties?:_____
Motor difficulties (e.g. clumsiness)?: _____
Does your child have difficulties with hygiene? _____

Please list any other healthcare providers involved in your child's care (e.g., neurologists, pediatricians or other physicians, psychologists, social workers, therapists, special educators, occupational therapists, etc.)

Medical History

Yes No Has your child's medical history been normal/unremarkable? If no, please explain:

Yes No Has your child received any medical diagnoses? Please specify:

Yes No	Has your child had genetic testing?	**Yes No**	Meningitis?
Yes No	Has your child had an MRI?	**Yes No**	Seizures?
Yes No	Has your child had an EEG?	**Yes No**	Asthma?
Yes No	Frequent ear infections?	**Yes No**	Slow/fast growth?
Yes No	Were ear tubes ever placed?	**Yes No**	Head injury?
Yes No	Hearing problems?	**Yes No**	Allergies?
Yes No	Vision problems?	**Yes No**	Hospitalizations? Describe below.
Yes No	Headaches?	**Yes No**	Physical/Sexual Abuse?

If yes to any of the above, please describe: _____

Has your child ever been hospitalized, had surgeries, or major illnesses?

Age	*How long*	*Reason*

What medications does your child currently take? (Include over-the-counter supplements)

Name	*Dose*	*Frequency*	*Reason*

Describe your child's sleep routine:

Typical bed time: _____ Typical wake time: _____

Trouble falling asleep? **Yes No** Trouble staying asleep? **Yes No** Trouble waking up early? **Yes No**

Any other sleep problems? Explain: _____

Describe your child's diet: _____

Describe your child's current level and type(s) of exercise: _____

Mental Health History

Has your child had previous neuropsychological testing? **Yes** **No**
If Yes, where? _____ When? _____

Has your child had any additional testing (e.g., psychoeducational, speech/language?) **Yes** **No**
If Yes, where? _____ When? _____
**If you answered Yes to either of the above questions, please attach or otherwise provide report(s).*

Has your child received psychotherapy services or counseling in the past? **Yes** **No**
If Yes: Name of provider: _____ Dates: _____

Is your child seeing a psychiatrist for medication? **Yes** **No** Or in the past? **Yes** **No**
Name of Psychiatrist: _____ Dates: _____
Medication the Psychiatrist Prescribed: _____

Is there any history of self-harm or suicidal thoughts, threats, or attempts? Please Explain: _____

List any previous or current mental health diagnoses: _____

Psychosocial Functioning

Describe the child's personality:

What are your child's non-academic strengths?

What are your child's non-academic weaknesses?

How does the child spend his/her free time?

In what community or extracurricular activities is your child involved?

Any concerns about child's social group/friends? Explain: _____

Any concerns about substance use? Explain: _____

_____

Please place a mark next to behaviors that you believe your child exhibits to an *excessive or exaggerated degree* when compared to other children his or her age.

Sleeping and Eating

- ❑ Nightmares
- ❑ Trouble falling asleep
- ❑ Trouble staying asleep in the morning
- ❑ Decreased need for sleep without getting tired
- ❑ Eats Poorly
- ❑ Eats excessively
- ❑ Excessive snoring during sleep

Social Development

- ❑ Prefers to be alone
- ❑ Excessively shy or timid
- ❑ More interested in objects than people
- ❑ Difficulty making friends
- ❑ Teased by other children
- ❑ Bullies other children
- ❑ Excessive daydreaming and fantasy life
- ❑ Not sought out for friendship by peers
- ❑ Difficulty seeing another person's point of view
- ❑ Doesn't empathize with others
- ❑ Overly trusting of others
- ❑ Doesn't appreciate humor

Behavior

- ❑ Stubborn
- ❑ Irritable, angry, or resentful
- ❑ Frequent tantrums
- ❑ Strikes out at others
- ❑ Throws or destroys things
- ❑ Lying
- ❑ Stealing
- ❑ Argues with Adults
- ❑ Low frustration threshold
- ❑ Daredevil behavior
- ❑ Runs away
- ❑ Needs a lot of supervision
- ❑ Impulsive (does things without thinking)
- ❑ Poor sense of danger
- ❑ Skips school
- ❑ Seems depressed
- ❑ Cries frequently
- ❑ Excessively worried and anxious
- ❑ Overly preoccupied with details
- ❑ Overly attached to certain objects
- ❑ Not affected by negative consequences
- ❑ Drug use
- ❑ Alcohol use
- ❑ Sexual activity, behavior, or sexual talk

Motor Skills

- ❑ Poor fine motor coordination
- ❑ Poor gross motor coordination
- ❑ Generally "clumsy"

Other problems

- ❑ Bladder control problems
- ❑ Poor bowel control (soils self)
- ❑ Any history of motor/vocal tics
- ❑ Overreacts to noises
- ❑ Overreacts to touch
- ❑ Problems with taste or smell

Academic History

Child's current grade: _____
School Name: _____ **Public Private**
School District: _____

What preschool experience did your child have? _____

Were there any problems detected in your child's kindergarten screening? **Yes No** If yes, please explain:

_____

Is your child in a regular classroom? **Yes No** If no, please explain: _____

_____

Does your child have an IEP or 504 Plan, or other modified learning program? **Yes No**

Please check any services child currently receives through an IEP or 504 Plan (if applicable):

_____ Speech therapy
_____ Occupational therapy
_____ Physical therapy
_____ Adaptive PE
_____ Tutoring
_____ Pull-out services (math, reading, writing)

What are your child's typical grades?

_____

_____

How does your child typically perform on standardized tests/district assessments?

_____

_____

What are your child's strongest and weakest points, academically?

_____

_____

Are you satisfied with your child's educational program? **Yes No** If no, please explain:

_____

_____

Family History

Parents are (choose one): **Married Separated Divorced Living Together**
If separated or divorced; how old was the child when the separation occurred? _____
Child lives with (choose one): **Both parents Mother Father Other**
Who has legal custody? _____
Who else lives in the home? _____

Biological Mother: Current age _____
Name _____
Occupation _____
Highest grade completed _____

Biological Father: Current age _____
Name _____
Occupation _____
Highest grade completed _____

Siblings:

Name	Age	Medical, social, academic, mental health concerns

Have any of the following conditions occurred among the child's blood relatives (parents, aunts, uncles, grandparents)? Check those that apply:

- ❑ Allergies
- ❑ Amnesia
- ❑ Asthma
- ❑ ADHD/ADD
- ❑ Bleeding tendency
- ❑ Depression/Bipolar disorder
- ❑ Cancer
- ❑ Suicide
- ❑ Dyslexia or math struggles
- ❑ Deafness
- ❑ Diabetes
- ❑ Glandular problems
- ❑ Heart diseases
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Alcohol/drug problem
- ❑ Anxiety/OCD/Panic
- ❑ Tics
- ❑ Autism/Asperger's
- ❑ Intellectual disability/cognitive delay
- ❑ Seizures
- ❑ Cerebral Palsy
- ❑ Migraines
- ❑ Muscular Dystrophy
- ❑ Other (specify): _____

Does anyone in the family have similar difficulties to the child? If yes, please describe:

If child is adopted…
Adoption source: _____
Reason and circumstances: _____
Age when child first in home: _____ Date of legal adoption: _____
What has the child been told regarding the adoption? _____

Legal History

Has the child been involved with the court currently or in the past? _____
Date(s): _____
Describe: _____

Current Probation? **Yes** **No** Probation Officer: _____ Phone #: _____