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Initial Parent Consultation: Background Information Form

Child Information

Child's full name:	Nickname:
Child's date of birth:	Child's place of birth:
Languages child hears (most frequent first):	
Languages child speaks (most frequent first):	
Age of each parent when child was born: _____ Mother _____ Father _____ Surrogate _____ Unknown	
Child lives with: ☐ Both ☐ Mother ☐ Father ☐ Surrogate ☐ Other (give name) _____	
Parents are: ☐ living together ☐ separated since _____ ☐ divorced since _____	
Legal Custody: ☐ Both ☐ Mother ☐ Father ☐ Guardian (give name) _____	
What are your child's strengths?	

What are your child's weaknesses?

Parent Information

Date of completion of form:	
Name of person completing form:	
Mother's name:	Father's name:
Mother's occupation:	Father's occupation:
Mother's languages:	Father's languages:
Home Address:	Home Address:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
E-mail:	E-mail:

Who referred you to me? How did you learn about my practice?

What are your reasons for seeking this consultation? (Include concerns about behavior at home or school, emotional development, social skills, and academic performance.)

Pregnancy Complications

- ☐ difficulty w/ conception ☐ nausea ☐ vomiting ☐ high BP ☐ X-rays ☐ bleeding ☐ toxemia ☐ eclampsia
☐ excessive swelling ☐ excessive weight gain ☐ measles ☐ mumps ☐ German measles ☐ anemia ☐ injury
☐ Rh incompatibility ☐ hospitalization ☐ rubella ☐ drugs, alcohol, other substances

Prescribed medications:

Other Complications:

Birth History

- ☐ full term ☐ premature ☐ post term; if atypical, length of pregnancy _____ ☐ bleeding ☐ forceps ☐ breech
☐ induced labor ☐ C-section ☐ infant jaundice; days under lights ____ ☐ infant breathing problems
☐ infant oxygen Apgar scores _____ (1 minute) _____ (5 minute) weight _____ length _____
☐ anesthesia; if yes list types: _____
 ____ days mother spent in hospital ____ days infant spent in hospital ____ days infant spent in NICU/ICU

Other:

Child Medical History

- ☐ failure to thrive ☐ allergies ☐ frequent colds ☐ frequent coughs ☐ asthma ☐ sinus problems
☐ ear infections ☐ snoring ☐ vision problems ☐ hearing problems ☐ headaches ☐ stomach aches
☐ heart murmur ☐ measles ☐ mumps ☐ rubella ☐ chicken pox ☐ tuberculosis ☐ whooping cough
☐ scarlet fever ☐ diphtheria ☐ rheumatic fever ☐ meningitis ☐ encephalitis ☐ anemia ☐ fever over 104 degrees
☐ ER visits ☐ broken bones ☐ hospitalizations ☐ seizures/epilepsy ☐ chronic illnesses ☐ surgeries
☐ head injuries; if yes how many? ____ list dates: _____
☐ concussions; if yes how many? ____ ☐ loss of consciousness; if yes how long? ____ ☐ CAT/MRI / DTI scans

If child has received concussions, give dates and cause:

If child has received CAT/MRI/DTI scans, give dates and reason:

My child is ☐ fully immunized ☐ partially immunized ☐ unimmunized

If child has some or no vaccinations, explain:

Medications taken: (list all drugs, dosage and frequency)

Caregiver History

Who is the primary caregiver(s) during weekdays:

Who is the primary caregiver(s) during evenings:

Who is the primary caregiver(s) on weekends:

If concerns, give details:

Developmental History

Please indicate age at which each of the following occurred. If actual age is not known, then indicate early (E), normal (N), or late (L). List approximate ages (in months or years)

- | | | | |
|--|-------------------------------------|--|---|
| ☐ first word | ☐ sitting up | ☐ clear hand preference | ☐ weaned to cup |
| ☐ 2 word combinations | ☐ crawling | ☐ RH or LH (circle) | ☐ bowel trained |
| ☐ sentences | ☐ standing | ☐ cutting with scissors | ☐ bladder trained, day |
| ☐ spoke clearly | ☐ cruising | ☐ printing name | ☐ bladder trained, night |
| ☐ named colors | ☐ walking | ☐ closing buttons | ☐ dressed self |
| ☐ named shapes | ☐ running | ☐ zipping | ☐ rode 2 wheel bike |

Has child received early intervention services (0 to 5 years) ☐ no ☐ yes, if yes check all that apply

☐ speech/language ☐ fine motor ☐ large motor ☐ play therapy ☐ CBT ☐ other

If concerns, describe:

Behavioral Characteristics

Check all characteristics that apply. If not applicable, leave blank. If uncertain, place question mark (?).

- | | | |
|---|---|---|
| ☐ coordination problems, tripping or falling
☐ difficulty with scissors, utensils
☐ difficulty with dressing
☐ difficulty with cutting, copying, pasting
☐ poor handwriting
☐ hyperactive
☐ impulsive
☐ restless, fidgety
☐ accident prone
☐ short attention span
☐ in school ☐ during group sports
☐ during social activities ☐ during homework
☐ poor concentration
☐ difficulty organizing materials
☐ disorganized work style
☐ needs continual direction, reminders | ☐ cannot shift from one activity to another
☐ change in eating habits
☐ change in sleep habits
☐ chooses not to talk in some situations
☐ delay in acquiring speech/language
☐ incorrect pronunciation of sounds
☐ grammatical mistakes in speech
☐ difficulty remembering what was said
☐ difficulty following oral directions
☐ slow to reply to oral questions
☐ difficulty retelling a story or event, in order
☐ frequent daydreaming | ☐ chooses not to talk in some situations
☐ poor school reports
☐ difficulty with reading
☐ difficulty with spelling
☐ difficulty with math
☐ difficulty completing homework
☐ poor grasp of time, is late
☐ confused about directions (right-left)
☐ difficulty getting along with peers
☐ persistent bedwetting
☐ temper tantrums
☐ difficult to control
☐ arguments with family members
☐ conduct problems (stealing, lying, fire setting, etc.) |
|---|---|---|

Sun

Mon

Tues

Weds

Thurs

Fri

Sat

7
8
9
10
11
12
1
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8
9

Which of these activities does your child look forward to?

Which of these activities does your child dislike or resist?

Siblings

Name _____

Age

Current grade/school or highest grade (note if not at home)

Educational History

Note: I must have written permission to contact schools or service providers.

Grade:

Present School:

School Phone:

School Address:

Beginning with preschool, list all of the schools that the child has attended and include the dates.

Child's
Age

Grade

Dates

Name of program/school

Educational Materials

List any material used at school or at home

Name of math textbook (indicate level) or program:

Name of literacy text or books assigned:

List three books that your child has chosen to read, independently, at home:

1)

2)

3)

List any other educational material, computer program, or educational classes outside of school, if child does not read independently, list books read to child:

Previous Evaluations

Has child been evaluated previously? ☐ yes ☐ no

Note: I will not contact these people unless you give me written permission on a separate consent form.

Type of Evaluation	Dates	Evaluator name and address
☐ Neuropsychological		
☐ Speech/Language		
☐ Hearing Test		
☐ Vision Test		
☐ Psychiatric		
☐ Neurological		
☐ Other		

Special Educational or Psychological Services your child has received

Check all that apply:

- ☐ reading remediation
- ☐ resource room
- ☐ private tutoring
- ☐ IEP/classification
- ☐ special ed. Class
- ☐ summer school
- ☐ other special services

- ☐ pull out enrichment
- ☐ part time gifted class
- ☐ full time gifted class
- ☐ EPGY
- ☐ CTY writing tutorial
- ☐ CTY summer camp
- ☐ other instruction

- ☐ physical therapy
- ☐ occupational therapy
- ☐ speech/language therapy
- ☐ psycho-therapy, child
- ☐ psycho-therapy, parent
- ☐ family therapy
- ☐ other therapy

Type of Service

Dates of Contacts

Frequency

Provider

Which of these professional services have been helpful?

Which of these professional services have not been helpful?

Use this section for any other information that you believe is important. Include any recent events such as moves, job changes, loss of family members or friends, parental illness or hospitalizations or sibling illnesses or hospitalizations and the like.

I acknowledge that I am the parent or legal guardian of this child, that I am legally empowered to consult regarding this child and that I will be responsible for the \$400 fee for the consultation session.

Name of child: _____ **Relationship to child:** _____

Completed by: _____
(Date) (Print name) (Sign name)

Please mail form to:

460 74th Street

Brooklyn, NY 11209

- OR -

Email to:

jbo2003@tc.columbia.edu