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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
- ☐ choses 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
- ☐ choses 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.)

Daily Schedule

Please list your child's daily schedule, including wake up time, school hours, after-school programs, activities, lessons, weekend obligations and bedtime.

	Sun	Mon	Tues	Weds	Thurs	Fri	Sat
7							
8							
9							
10							
11							
12							
1							
2							
3							
4							
5							
6							
7							
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	☐ pull out enrichment	☐ physical therapy
☐ resource room	☐ part time gifted class	☐ occupational therapy
☐ private tutoring	☐ full time gifted class	☐ speech/language therapcy
☐ IEP/classification	☐ EPGY	☐ psycho-therapy, child
☐ special ed. Class	☐ CTY writing tutorial	☐ psycho-therapy, parent
☐ summer school	☐ CTY summer camp	☐ family therapy
☐ other special services	☐ other instruction	☐ other therapy

Professional Contacts			
Please list all of the professionals who have worked with your child and indicate approximate dates. Include current classroom teacher, remediation specialist or school counselor. ***I will not contact these people unless you give me written permission on a separate consent form.***			
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 St., 1B
Brooklyn, NY 11209
- OR-
Fax to:
1-718-680-8332