CHILD EVALUATION FORM

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Please fill out this biographical background form as completely as possible for your child. It will help me in our work together. Please print or write clearly.

Child's Name: _____ ❒ Female ❒ Male Date :_____

D.O.B: _____Age: _____ Birthplace: _____

Parents Current Marital Status: ❒Married ❒Separated ❒ Divorced ❒ Never Married

Legal Custody Arrangement: _____
*Please attach court documentation of the custody plan when parents are not married

With whom is your child residing?

- ❒ Both Biological Parents
- ❒ Biological Mother Only
- ❒ Biological Father Only
- ❒ Adoptive Parents (Age at Adoption _____)
- ❒ Maternal Grandparents
- ❒ Paternal Grandparents
- ❒ Biological Mother and Step Father
- ❒ Biological Father and Step Mother
- ❒ Other _____

Child's Address:
Street: _____ City, State, Zip: _____

Mother's Information:
Name: _____ DOB: _____
Address (if different than child's or if joint custody) _____
Phone: H: _____ Cell: _____ Work: _____
Email: _____
Do you consent to receive emails from Dr. Robinson? ❒ Y ❒ N
Which phone #'s may be used for confidential messages? ❒ Home ❒ Cell ❒ Work

Father's Information:
Name: _____ DOB: _____
Address (if different than child's or if joint custody): _____
Phone: H: _____ Cell: _____ Work: _____
Email: _____
Do you consent to receive emails from Dr. Robinson? ❒ Y ❒ N
Which phone #'s may be used for confidential messages? ❒Home ❒ Cell ❒Work

Emergency Contact Information:

NAME: _____ Relationship: _____ Phone: _____

Referral Source: _____

Health Plan Information:

Primary Plan: _____ Policy/Subscriber #: _____
Subscriber's Name: _____ D.O.B: _____
Soc. Sec. #: _____
Plan Ph#: _____ Claim Address: _____

Secondary Plan: _____ Policy/ Subscriber #: _____
Subscriber's Name: _____ D.O.B: _____
Soc. Sec. #: _____
Plan Ph #: _____ Claim Address: _____

Presenting Problems (be as specific as you can: describe problems, when did it start,…):
1. _____
   _____
2. _____
   _____
3. _____
   _____

Estimate the severity of above problem: ❒ Mild ❒ Moderate ❒ Severe ❒ Very Severe

Education History:

Child's Current Grade: _____ Name of School: _____

Special Education/I.E.P Information:
_____
_____
_____

❒ GATE Program _____

Early Intervention? (Ages 0-3) If yes, please describe.

- ❒ Speech / Language Therapy _____
- ❒ Occupational Therapy _____
- ❒ Physical Therapy _____
- ❒ Other _____

Between Age 3 and current grade, did you child receive any therapies? If so, please describe.

_____
_____
_____
_____

Have teachers had any concerns about your child behaviorally or academically?

In Elementary School?

_____
_____
_____
_____
_____

In Middle School?

_____
_____
_____
_____
_____

In High School?

_____
_____
_____
_____
_____

What are child's favorite subjects/academic strengths?

_____
_____

What are child's least favorite subjects/ academic weaknesses?

_____
_____

Typical Grades Child Earns: _____Math _____ Reading _____Spelling _____Writing _____Comprehension

Birth History:

Were there any substances used during pregnancy? _____

Were there any concerns during pregnancy, labor, delivery?

_____

_____

How was your child delivered? ❒ Vaginal ❒ Cesarean Section

Was child born prematurely? If so, how many weeks old at birth? _____

How many days after birth was infant released from the hospital? _____

Infant's weight at birth: _____

NICU hospitalization: # of days _____

❒ Incubator ❒ Jaundice ❒ Infantile Seizures ❒Problems with feeding

❒Other _____

Developmental History:

O= On time E= Early D= Delayed

_____Crawling_____ Sitting _____ Standing _____Walking _____Talking ____Toilet Training

Did your child have difficulty with any of the following during their first year?

- ❒ Did not enjoy cuddling
- ❒ Was not calmed by being held or stroked
- ❒ Difficult to comfort
- ❒ Colic
- ❒ Excessive restlessness
- ❒ Excessive irritability
- ❒ Diminished sleep
- ❒ Frequent head banging
- ❒ Problems with nursing or taking bottle

Medical History:

Height: _____ Weight: _____

Current Medication: (Name of Medication, Dosage, Reason Prescribed, Helpful or Not Helpful)

1. _____
2. _____
3. _____
4. _____

Past Medication (Name of Medication, Reason Prescribed, Helpful or Not Helpful, Reason Discontinued):_____

_____

_____

_____

Current Pediatrician (Name/ Phone/ City): _____

Specialists (Name/ Specialty/ Phone/ City): _____

Describe Any Serious Medical Conditions

_____

_____

_____

_____

Surgeries (Age, Type of Surgery, Outcome):

_____

_____

_____

Accidents / Falls/ Head Injuries: _____

_____

Allergies/Asthma: _____

_____

Chronic Ear Infections/tubes: _____

Ear/ Hearing Problems: _____

Eye/Vision Problems: _____

Accident Prone/ Clumsy/ Coordination Problems: _____

Appetite/ Eating Problems: _____

Past/Present Psychotherapy/Counseling: (specify: month year/s (beginning—end), estimated no. of sessions, name, degree, phone & address of therapist, initial reason for therapy, Indiv. Or Family, brief description of the relationship and how helpful it was, and how/why it ended):

_____

_____

_____

_____

_____

Child's Past/Present Drug/Alcohol Use/Abuse (AA, NA, treatments):

_____

_____

_____

Suicide Attempts/Violent Behavior (describe: ages, reasons, circumstances, etc) -
_____
_____
_____

Family History:

Parents Occupation/Careers/Current Employer:
Mother: _____
Father: _____
Step Mother: _____
Step Father: _____

Child's Siblings (name, age, full-step-half, statement about their relationship, if deceased: age and cause of death):

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____

Family History of Medical Issues:
Maternal Side: _____
_____
_____
Paternal Side: _____
_____
_____

Parents Present and Past Marriages (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):
_____
_____
_____
_____
_____
_____

If parents are divorced, what was child's age at the time _____ and how did it effect child?

_____
_____
_____
_____

Family History of Alcoholism/Addiction, Mental Illness, or Violence (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

_____
_____
_____
_____
_____

Describe your child's recreational activities/hobbies:

_____
_____
_____

Describe your family's strengths:

_____
_____

Describe your child's relationships with friends/peers:

_____
_____

Is spirituality / faith an area of support or strength for your child? ❒ Yes ❒ No
Religion: ❒ Catholic ❒ Jewish ❒ Protestant ❒ Other Christian _____
❒ Islamic ❒ Buddhist ❒ Other: _____

Would you like your child to receive Christian based counseling when appropriate? ❒ Yes ❒ No
❒ Maybe, please let me know before speaking with my child

Legal History:
Are you involved in any current or pending civil or criminal litigations, lawsuits, divorce or custody disputes? (if you answer Yes, please explain):

_____
_____
_____
_____
_____

Please add any information you feel is important to your child's treatment:

_____
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_____

_____	_____	_____
Parent/Guardian Name (print)	Parent/Guardian Signature	Date
_____	_____	_____
Parent/Guardian Name (print)	Parent/Guardian Signature	Date