Child Background History Form

Name of child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Click or tap here to enter text. Birthdate: \_\_\_/\_\_\_/\_\_\_

Home address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caregiver’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_

Educational level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caregiver’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_

Educational level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you for this evaluation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly indicate the reasons for the present evaluation:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Circumstances/factors you think are important regarding this decision:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you in agreement with this referral? Yes/No (If no please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREGNANCY:

1. Was this child adopted? yes \_\_\_\_ (skip to Early History Section)

no \_\_\_\_ (complete below)

2. Age of mother at delivery \_\_\_\_\_

3. Age of father at delivery \_\_\_\_\_

4. How much did your child weigh at birth? \_\_\_\_\_pounds \_\_\_\_\_ounces

5. Length of Pregnancy \_\_\_\_\_\_

6. Did you experience any prenatal complications? yes \_\_\_\_ no\_\_\_\_

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Did you take any medications during pregnancy? yes \_\_\_\_ no \_\_\_\_

If yes, what medications did you take, for what reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. During your pregnancy with this child, did you use any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Amount |
| Alcohol |  |  |  |
| Tobacco |  |  |  |
| Cocaine |  |  |  |
| Other drugs |  |  |  |

BIRTH HISTORY:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | If yes, please describe |
| Was the birth a cesarean section? |  |  |  |
| Was labor induced? |  |  |  |
| Were you given medication during labor? |  |  |  |
| Was anesthesia used during labor? |  |  |  |
| Was this a multiple birth? |  |  |  |
| Was the baby born head-first? |  |  |  |
| Were forceps used during delivery? |  |  |  |
| Did your baby have any breathing problems? |  |  |  |
| Was your baby born with cord wrapped around neck? |  |  |  |
| Did your baby have low Apgar scores? |  |  |  |
| Did your baby require incubation? |  |  |  |
| Did your baby receive oxygen? |  |  |  |
| Did your baby require phototherapy? (jaundice) |  |  |  |
| Was your baby colicky? |  |  |  |
| Did this baby have any feeding problems? |  |  |  |
| Was the baby normally active? |  |  |  |
| Did the baby fail to grow normally or gain weight? |  |  |  |
| Was this baby different in any way from brothers or sisters? |  |  |  |

EARLY HISTORY:

1. At approximately what age did this child:

|  |  |
| --- | --- |
|  | Age (in months) |
| Sit alone |  |
| Walk alone |  |
| Speak 1st words |  |
| First put words together meaningfully |  |
| Talk in complete sentences |  |
| Become toilet trained for bladder |  |
| Become toilet trained for bowel |  |

2. Does your child have any speech or language problems? yes\_\_\_\_ no\_\_\_\_

If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Is English the child’s first language? yes\_\_\_\_ no\_\_\_\_

If no, what is child’s first language?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How old was your child when s/he learned to speak English?\_\_\_\_\_

MEDICAL HISTORY

1. Has your child had any of the following?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes | No | Age | If yes, Explanation |
| Head Injury |  |  |  |  |
| Loss of consciousness |  |  |  |  |
| Meningitis |  |  |  |  |
| Encephalitis |  |  |  |  |
| Seizures |  |  |  |  |
| High Fever |  |  |  |  |
| Strep Throat |  |  |  |  |
| Ear Infections |  |  |  |  |
| Myringotomy tubes (tubes in ears) |  |  |  |  |
| Vision Problems |  |  |  |  |
| Hearing Problems |  |  |  |  |
| Heart Disease |  |  |  |  |
| Asthma |  |  |  |  |
| Chicken Pox |  |  |  |  |
| Mumps |  |  |  |  |
| German Measles (rubella) |  |  |  |  |
| Measles (rubeola) |  |  |  |  |
| Other serious illness: |  |  |  |  |

2. Is your child currently taking any medications? yes\_\_\_\_ no\_\_\_\_If yes:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Dosage | Dates | Reason | Prescribed by |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

3. Has your child had any of the following tests?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes | No | Date | What was the result? |
| Eye Exam |  |  |  |  |
| Hearing Test |  |  |  |  |
| EEG |  |  |  |  |
| MRI |  |  |  |  |
| CT Scan |  |  |  |  |

4. Has your child ever been hospitalized? yes\_\_\_\_ no\_\_\_\_

If yes:

|  |  |  |
| --- | --- | --- |
| Reason for Hospitalization | Age of Child | Length of Stay |
|  |  |  |
|  |  |  |
|  |  |  |

FAMILY MEDICAL HISTORY

1. Is there anyone in your immediate or extended family who has (or had) any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | If yes, who (relationship to child) |
| Learning problems |  |  |  |
| Neurological disease |  |  |  |
| Seizures (epilepsy) |  |  |  |
| Intellectual Disablity |  |  |  |
| Autism/Developmental Disorder |  |  |  |
| Attentional problems |  |  |  |
| Behavioral problems |  |  |  |
| Alcohol/Substance Abuse |  |  |  |
| Depression |  |  |  |
| Manic-Depression/Bipolar |  |  |  |
| Anxiety Disorder |  |  |  |
| Obsessive-Compulsive Disorder |  |  |  |
| Schizophrenia |  |  |  |
| Other psychiatric problems |  |  |  |
| Diabetes |  |  |  |
| Cancer |  |  |  |
| High blood pressure |  |  |  |
| Heart disease |  |  |  |
| Alzheimer’s Disease/Dementia |  |  |  |
| Other disease/health problem that runs in family |  |  |  |

SOCIAL/EMOTIONAL/BEHAVIORAL HISTORY

1. Are the parents: \_\_\_\_\_married date:\_\_\_\_\_\_\_

\_\_\_\_\_domestic partners date:\_\_\_\_\_\_\_

\_\_\_\_\_separated date:\_\_\_\_\_\_\_

\_\_\_\_\_divorced date:\_\_\_\_\_\_\_

\_\_\_\_\_never married

1. If parents are divorced, what are the custody arrangements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If either or both parent(s) have remarried, please fill in the following section regarding step-parents or additional caregivers:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does your child have any siblings? no\_\_\_\_ yes\_\_\_\_ (please complete below)

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  |  |  |
| Age: |  |  |  |
| Grades repeated: |  |  |  |
| Learning or Emotional Difficulties: |  |  |  |

5. Who lives with your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Would you describe your child as:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | If yes, please describe |
| Shy |  |  |  |
| Well Behaved |  |  |  |
| Impulsive |  |  |  |
| Clumsy |  |  |  |
| Immature |  |  |  |
| Stubborn |  |  |  |
| More active than other children |  |  |  |

7. Has your child received any psychological or psychiatric treatment? yes\_\_\_\_ no\_\_\_\_

If yes, please complete below:

|  |  |  |
| --- | --- | --- |
| Provider | Primary reason for seeking treatment | Dates |
|  |  |  |
|  |  |  |
|  |  |  |

8. Please indicate any past evaluation and treatment diagnoses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. How would you describe your child’s personality?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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10. How does your child get along with other children? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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11. Do you have any concern about your child’s behavior? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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12. Do you have any concern about your child’s emotional well-being? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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13. What forms of discipline do you use with your child?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are they successful?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. Please describe any family stressors or stressful life events:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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15. Please describe the best things about your child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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16. Does your child have or did your child ever have:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | If yes, please list approx. age and a  brief description of the problem |
| Temper tantrums |  |  |  |
| Sleep problems |  |  |  |
| Nightmares |  |  |  |
| Blank Spells/Staring Spells |  |  |  |
| Falling Spells |  |  |  |
| Sensory Integration Issues |  |  |  |
| Poor Handwriting |  |  |  |
| Head Banging |  |  |  |
| Toe Walking |  |  |  |
| Thumb Sucking |  |  |  |
| Tics or Twitching |  |  |  |
| Repetitive Motions |  |  |  |
| Difficulty with transitions |  |  |  |
| Difficulty staying with an activity |  |  |  |
| Bedwetting after age 5 |  |  |  |
| Eating paper, paint, etc. |  |  |  |
| Emotional Problems |  |  |  |
| Adjustment Problems |  |  |  |
| Behavioral Problems |  |  |  |

SCHOOL HISTORY

1. At what age did your child begin school? \_\_\_\_\_\_\_

2. What grade is your child currently in? \_\_\_\_\_\_\_

3. What school does your child currently attend? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. What is (are) the name of your child’s teacher(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Please list all schools your child has attended:

|  |  |  |
| --- | --- | --- |
| Grade(s) | Name of School | Years Attended  (ie. 1996-1997) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

6. Within the past year has the school reported problems with:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Indicate nature of problem |
| Reading |  |  |  |
| Spelling |  |  |  |
| Writing |  |  |  |
| Arithmetic |  |  |  |
| Behavior |  |  |  |
| Social Adjustment |  |  |  |
| Attention Span |  |  |  |
| Following Directions |  |  |  |

7. Does your child like school? yes\_\_\_\_ no\_\_\_\_

8. During the past school year, how many days of school did your child miss?\_\_\_\_\_\_\_\_

9. Briefly describe your child’s school experiences with regard to academic performance:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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10. What kinds of grades does your child typically earn?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Briefly describe your child’s school experiences with regard to behavior/attention:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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12. If your child has had any difficulties in school (academic or behavioral),

in which grade did these problems start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does your child have any difficulties with completion of homework? Please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Please describe your child’s hobbies, sports, or involvement in clubs/groups:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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15. Has your child:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes | No | Grade(s) | Description |
| Been in accelerated classes or classes for the gifted? |  |  |  |  |
| Been retained in any grade? |  |  |  |  |
| Received tutoring? |  |  |  |  |
| Received resource support? |  |  |  |  |
| Been in a self-contained  Special education classroom? |  |  |  |  |

14. Is your child currently eligible for special education services? yes\_\_\_\_ no\_\_\_\_

If yes, is it because of (check all that apply)

Specific Learning Disability \_\_\_\_\_

Intellectual Disability \_\_\_\_\_

Speech/Language Impairment \_\_\_\_\_

Emotional/Behavioral Disability \_\_\_\_\_

Other Health Impaired \_\_\_\_\_

1. Please specify any special education support your child currently is receiving:

|  |  |  |
| --- | --- | --- |
|  | What grade (s)? | Who provides service? |
| Reading |  |  |
| Written Language |  |  |
| Math |  |  |
| Speech/language |  |  |
| Occupational Therapy |  |  |
| Physical Therapy |  |  |

Person completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE ENCLOSE ANY PREVIOUS REPORTS TO MAXIMIZE THE BENEFITS OF THIS EVALUATION AND TO ASSURE THAT THE SAME TESTS ARE NOT GIVEN REPEATEDLY, POSSIBLY INVALIDATING RESULTS.**