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CONSULTATION FORM

DATE OF CONSULTATION

NAME		DATE OF BIRTH	AGE
CURRENT GRADE	SCHOOL		
PARENT(S) NAME(S)			
ADDRESS			
HOME PHONE	CELL PHONE	EMAIL	
WORK PHONE	REFERRED BY		

Name of the person completing form

Relationship to the child

Please list any other siblings and their ages.

Primary Concerns (attach additional information)

Does the child have any school behavior problems?

Please describe the child’s strengths.

Please describe the child’s challenges.

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CONSULTATION FORM CONTINUED

Father's Occupation | Employer

Employer's Address | Phone

Father's Age | Father's Education — highest-level completed

Mother's Occupation | Employer

Employer's Address | Phone

Mother's Age | Mother's Education — highest-level completed

Has either parent been divorced? | When? | Are both parents living?

Is the child (select one) ☐ Natural ☐ Adopted ☐ Fostered

Whom does this child live with at the present time? (Include parents, brothers, sisters, grandparents, friends, & etc.)

What language is used at home?

Please list anyone in the family with problems in school:

Person (grandparents, brothers, sisters, uncles, aunts, etc.)	Problem (Language, reading, writing, spelling, mathematics, processing skills, etc.)

Please list anyone in the family with behavioral problems:

Person (grandparents, brothers, sisters, uncles, aunts, etc.)	Problem (overactive, restless, depression, trouble with the law, psychological diagnosis, etc.)

Has anyone in the family suffered from:

	Person
☐ seizures/epilepsy?	
☐ other neurological disease or disorder?	
☐ emotional problems?	
☐ cognitive disability?	

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CONSULTATION FORM CONTINUED

Birth History

Was the pregnancy with this child different from any others?

How?

Medications taken during pregnancy:

Did you or your doctor note any problems with:

☐ Pregnancy?

☐ Labor?

At birth any problems with baby's:

☐ Breathing ☐ Heartbeat ☐ Birth Weight

How long were mother/baby in the hospital?

Which (1st, 2nd, etc) of mother's pregnancies?

Was child full term (was he/she born at the expected time)?

Age of mother at delivery? Age of father?

Medical History (child)

Condition of baby at birth?

Jaundice, "Rh" problems, chemical abnormalities?

Were seizures/convulsions associated with high fever?

Has the child had any serious illness? What?

When? How long?

Has the child ever been hospitalized? Why?

When? How long?

Has the child had any operations? What?

When?

Does the child have any allergies to:

☐ Milk ☐ Food ☐ Medications

☐ Environmental ☐ Other

Has the child had any head injuries? What happened?

When? Was the child unconscious?

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CONSULTATION FORM CONTINUED

Medical History (child) continued

List medications child takes:

How often does the child have headaches?

How are these treated?

Does the child have prescription lenses/contacts? Date last tested?

Does the child have hearing problems (please specify)?

Date last tested?

Does the child have a history of frequent ear infections?

How often? When?

Choose one: ☐ Left Handed ☐ Right Handed

Movement: (coordination, always moving, twitching, tics, head banging, rocking, etc.)

Developmental History

As an infant, was this child fussy?

Over-sleepy/difficult to arouse?

Did this child respond to cuddling?

Compared to other children, did this child have difficulty learning?

- ☐ to talk?
- ☐ to understand?
- ☐ gross motor skills (walking, hopping, riding bicycle, etc.)

Compared to other children, did this child have difficulty learning?

- ☐ fine motor skills (fastening buttons, zippers, tying shoelaces, drawing, etc.)
- ☐ early school-related skills (naming colors, saying alphabet)
- ☐ to sit still for TV or stories?
- ☐ to play/socialize with other children?
- ☐ to build with blocks, play with puzzles, draw pictures?

Has this child had difficulty in separating? At what age?

At what age was this child toilet trained for a day? For a night?

Does this child have any sleeping difficulties?

Does this child have any eating difficulties?

Does this child play with older, younger, or same-age children?

Does this child have the opportunity to play with children the same age?

Has this child ever had any psychotherapy or counseling?

When?

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CONSULTATION FORM CONTINUED

School History

Present school address

Has the child ever repeated a grade? Which?

Has the child skipped any grades?

Is retention a consideration?

Please list the schools your child attended:

Grade Level	Name of School	Location

Did the child have pre-kindergarten screening?

What results were communicated?

In what grade did school problems become noticeable?

Has the child ever been evaluated for special education purposes?

During what grades?

Has the child been absent from school for long periods? In what grades?

Reasons?

Has the child ever received any special education services?

What type?

During what grades?

Who suggested that you get this evaluation at this time?

What is your child's attitude concerning school?

Concerning instructors?

What do you view as the major difficulties your child is experiencing (academic, behavioral, emotional, social or conceptual)?

Signature - Parent/Guardian Date