Previous Client Psychological and Medical History

Psychological

Previous Diagnoses:	Diagnosing Physician:	Date Provided:	Date Removed:

Has your child ever had suicidal ideation? ☐ Yes ☐ No

If **yes**, please describe in detail:	

Medical

Previous Diagnoses:	Diagnosing Physician:	Date Provided:	Date Removed:

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had:

Medications

Name:	Dosage:	Frequency:	Use:	Side Effects:	Prescriber:	Use Duration:

Testing			
Has your child had any of the following medical tests conducted and if so, what was the outcome?			
Test:	**Yes:**	**No:**	**Outcome:**
Hearing	☐	☐	
Vision	☐	☐	
MRI / Brain Scan	☐	☐	
Genetic Testing	☐	☐	
Allergy Testing	☐	☐	

Treatment		
Is your child up to date on **all** of his / her vaccinations?	☐ Yes	☐ No
Does your child regularly visit his / her pediatrician or primary care physician?	☐ Yes	☐ No
Does your child regularly visit a dentist?	☐ Yes	☐ No
Does your child regularly visit an optometrist?	☐ Yes	☐ No
Does your child regularly visit an audiologist?	☐ Yes	☐ No

Client Developmental History

Prenatal and Delivery

Were there any complications during **pregnancy**?		☐ Yes	☐ No
If **yes**, please describe complications and any corresponding treatment details:			
Was birth at full term?		☐ Yes	☐ No
If **no**, please describe in detail:			
Delivery**:** ☐ Spontaneous ☐ Induced ☐ Vaginal ☐ C-Section ☐ Other:			
Birth Weight:	pounds ounces	Birth Height:	inches
Were there any complications during **delivery**?		☐ Yes	☐ No
If **yes**, please describe complications and any corresponding treatment details:			

Were there any concerns **post-delivery**?	☐ Yes	☐ No
If **yes**, please describe complications and any corresponding treatment details:		

Postnatal and Developmental

Were there any significant illnesses during your child's **first year**?	☐ Yes	☐ No
If **yes**, please describe complications and any corresponding treatment details:		

Milestones	Estimated Age of Onset:									
	4M	6M	9M	1Y	1.5Y	2Y	3Y	4Y	5Y	N/A
Babbling.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Holding head up (unsupported).	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stringing vowels together (e.g., "ah," "eh," "oh").	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Making consonant sounds (e.g., jabbering with "m," "b").	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Rolling over consistently in both directions (front – back, back – front).	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Using finger to point at things.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pulling to stand and stand (when holding on).	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sitting up (unsupported).	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Crawling.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Saying at least one single word(s) (intelligible to others).	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cruising (i.e., walking while holding onto furniture).	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Saying several single word(s) (intelligible to others).	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walking (unassisted).	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Saying first two-word phrase(s) intelligible to others.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Saying first three-word phrase(s) intelligible to others.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Standing on tiptoe.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Running.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Climbing onto and down from things (unassisted).	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walking up and down stairs (one foot per each step).	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Using sentences regularly in speech.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Speaking very clearly and can carry on conversations with others.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Toilet trained.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Client Educational Information

Current

Name of School:			Years Attended:
Address:		Phone:	
City, State, Zip:		Email:	
School District:		School Type:	
Principal Name:	Teacher(s) Name(s):	Teacher Aide(s) Name(s):	
Grade:	Placement:	Number of Students:	Weekly Hours in School:

Has your child ever had, or does he / she currently have, any of the following within his or her school setting? (Please check all that apply).

☐ Functional Behavior Assessment ☐ Behavior Intervention Plan

☐ Individualized Education Plan ☐ Other: _____

Please attach all supporting educational documents.

Does your child's teacher have concerns about him / her and his / her performance?

☐ Yes ☐ No

Please Describe:

Does this school provide your child with a one-to-one aide in his or her classroom?

☐ Yes ☐ No

Comment:

Do you believe this school is meeting your child's academic needs? ☐ Yes ☐ No

Please Describe:

History

Name of School:		Years Attended:
Address:	Phone:	
City, State, Zip:	Email:	
School District:	School Type:	

Other Treatment Providers

Current Services

Type:	Contact:	Location:		Start Date:	Hours:	Outcomes:	
		Home	School			Satisfied	Unsatisfied
Behavior Therapy		☐	☐			☐	☐
Psychotherapy		☐	☐			☐	☐
Speech Therapy		☐	☐			☐	☐
Occupational Therapy		☐	☐			☐	☐
Physical Therapy		☐	☐			☐	☐
Social Skills		☐	☐			☐	☐
Other: _____		☐	☐			☐	☐

Previous Services

Type:	Contact:	Location:		Dates of Treatment:	Hours:	Outcomes:	
		Home	School			Satisfied	Unsatisfied
Behavior Therapy		☐	☐			☐	☐
Psychotherapy		☐	☐			☐	☐
Speech Therapy		☐	☐			☐	☐
Occupational Therapy		☐	☐			☐	☐
Physical Therapy		☐	☐			☐	☐
Social Skills		☐	☐			☐	☐
Other: _____		☐	☐			☐	☐

Please attach most recent supporting documents (e.g., evaluation, initial report, progress report, etc.)

Daily Living

Ecological Arrangements

Primary Language(s) Spoken in Home:	Child's Extracurricular Activities:

Please describe any cultural, religious, ethnic, or social beliefs about physical or mental health or illness that you feel would help us in understanding your child and family:

Confidence and Success during Community Outings: ☐ Good ☐ Fair ☐ Poor	Exclusive Room(s) / Space(s) for Conducting Therapy: ☐ Yes ☐ No	Exclusive Table for Conducting Therapy: ☐ Yes ☐ No
Notes:	***Notes***:	***Notes***:
Lighting in the Home: ☐ Bright ☐ Moderate ☐ Dim	Noise Level in the Home: ☐ Loud ☐ Moderate ☐ Quiet	Commotion in the Home: ☐ High ☐ Moderate ☐ Low
Notes:	***Notes***:	***Notes***:
Access to Toys: ☐ Free ☐ Restricted ☐ Mixed	Access to Food: ☐ Free ☐ Restricted ☐ Mixed	Access to Electronics: ☐ Free ☐ Restricted ☐ Mixed
Notes:	***Notes***:	***Notes***:

List All Individuals <u>Currently</u> Living in the Home of the Child:

Name:	Relationship:	Age:	Gender:

List All Individuals Significant to Your Child, but <u>NOT</u> Currently Living in Their Home:

Name:	Relationship:	Age:	Gender:

Functional Behavior Assessment Interview

Sleep Disturbances

How would you describe the quality of your child's sleep? ☐ Good ☐ Fair ☐ Poor

If **fair or poor**, please describe:	

Eating Patterns			
How would you describe your child's food consumption?	☐ Good	☐ Fair	☐ Poor
Is your child a picky eater?	☐ Yes	☐ No	
Is your child on any special diet?	☐ Yes	☐ No	
If consumption is **fair or poor**, or if a **picky eater** or on a **special diet**, please describe:			

Motor Dysfunction			
How would you describe your child's gross motor functioning?	☐ Good	☐ Fair	☐ Poor
How would you describe your child's fine motor functioning?	☐ Good	☐ Fair	☐ Poor
If either is **fair or poor**, please describe:			

Problem Behavior	
Briefly describe how your child's behaviors would be affected under the following conditions.	
Asked to perform a difficult task:	
Interrupted a desired activity:	
Unexpected change in routine:	

Denied something he wanted:	
Not given attention / left alone for a long period of time:	

Strategies	
Successful	***Unsuccessful***

Strengths

Reinforcement Inventory

Fisher, Piazza, Bowman, & Amari (1996)

Visual Stimuli

Does your child enjoy looking at things such as mirrors, bright lights, shiny objects, spinning objects, YouTube videos, television, etc.?	☐ Yes	☐ No
Please describe all visual stimuli your child **most** likes to watch:		

Auditory Stimuli

Does your child enjoy different sounds such as cars, nature, whistles, beeping noises, sirens, clapping, music, podcasts, audiobooks, social praise, etc.?	☐ Yes	☐ No
Please describe all auditory stimuli your child **most** likes to listen to:		

Olfactory Stimuli

Does your child enjoy different smells such as essential oils, pine trees, flowers perfume, coffee, laundry detergent, candles, etc.?	☐ Yes	☐ No
Please describe all olfactory stimuli your child **most** likes to smell:		

Gustatory Stimuli

Does your child enjoy particular foods or snacks such as candy, ice cream, pizza, juice, smoothies, graham crackers, chips, fruit, McDonald's, etc.?	☐ Yes	☐ No
Please describe all gustatory stimuli your child **most** likes to eat:		

Proprioceptive Stimuli

Does your child enjoy physical play or movement such as being tickled, hugs, pats on the back, high fives, wrestling, running, dancing, swinging, etc.?	☐ Yes	☐ No
Please describe all proprioceptive stimuli your child **most** likes:		

Tactile Stimuli		
Does your child enjoy touching things of different temperatures (e.g., cold things like snow or an ice pack, or warm things like a hand warmer or cup containing hot tea or coffee) or textures (e.g., smooth, rough, or slippery)?	☐ Yes	☐ No
Does your child enjoy feeling different sensations such as splashing water in a sink, a vibration against the skin, air blown on the face from a fan, etc.?	☐ Yes	☐ No
Please describe all tactile stimuli your child **most** likes:		

Tangible Stimuli		
Does your child enjoy certain toys, objects, or activities, such as puzzles, bubbles, blocks or Legos, dolls, computer or video games, tablet applications, arts and crafts, etc.?	☐ Yes	☐ No
Please describe all tangible stimuli your child **most** likes to play or to play with:		

Other	
Please describe any other things that your child **most** likes:	

Hierarchical Ranking of Stimuli:

	Highest Preferred	Moderately Preferred	Lowest Preferred
1.			
2.			
3.			
4.			
5.			

Please list any items you would <u>not</u> like used:	***Please list any items you would like used in <u>moderation</u>:***

Please list any items you would <u>not</u> want restricted for use within the context of treatment:

Current Custody Agreement

Parents Are:	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
	☐ Remarried	☐ Cohabitants	☐ Single	☐ Other:
Custodial Arrangement:	☐ Joint	☐ Shared	☐ Alternating	☐ Bird's Nest
	☐ Sole	☐ Split	☐ Third Party	☐ Other:

Please Explain in Detail:

Attach Legal Custody Agreement.

Legal Guardian Information

Mother

Last Name:	First Name:	Nickname:	
Date of Birth:		Social Security:	
Ethnicity:		Language(s) Spoken:	
Address (**if different from child**):		City, State, Zip:	
Home Phone:	Cell Phone:	Work Phone:	Preferred: ☐ Home ☐ Cell ☐ Work
Fax:	Email:		Preferred: ☐ Fax ☐ Email
Occupation:	Employer:	Highest Education Degree:	
Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor		Percentage of Time Spent with Client:	

Father

Last Name:	First Name:	Nickname:	
Date of Birth:		Social Security:	
Ethnicity:		Language(s) Spoken:	
Address (**if different from child**):		City, State, Zip:	

Home Phone:	Cell Phone:	Work Phone:	Preferred: ☐ Home ☐ Cell ☐ Work
Fax:	Email:		Preferred: ☐ Fax ☐ Email
Occupation:	Employer:	Highest Education Degree:	
Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor	Percentage of Time Spent with Client:		

Third Party

Last Name:	First Name:	Nickname:
Date of Birth:	Social Security:	
Ethnicity:	Language(s) Spoken:	
Address (**if different from child**):	City, State, Zip:	

Home Phone:	Cell Phone:	Work Phone:	Preferred: ☐ Home ☐ Cell ☐ Work
Fax:	Email:		Preferred: ☐ Fax ☐ Email
Occupation:	Employer:	Highest Education Degree:	
Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor	Percentage of Time Spent with Client:		

Stepmother

Last Name:	First Name:	Nickname:
Ethnicity:	Language(s) Spoken:	Percentage of Time Spent with Child:

Home Phone:	Cell Phone:	Work Phone:	Preferred: ☐ Home ☐ Cell ☐ Work

Stepfather

Last Name:	First Name:	Nickname:
Ethnicity: asdfasdf	Language(s) Spoken:	Percentage of Time Spent with Child:

Home Phone:	Cell Phone:	Work Phone:	Preferred: ☐ Home ☐ Cell ☐ Work

Family Psychological and Medical History

Family Psychological

Diagnosis:	Yes:	No:	Who?	Current? Yes:	Current? No:
Intellectual Disability	☐	☐		☐	☐
Communication Disorder	☐	☐		☐	☐
Autism Spectrum Disorder	☐	☐		☐	☐
Attention-Deficit / Hyperactivity Disorder	☐	☐		☐	☐
Specific Learning Disorder	☐	☐		☐	☐
Motor or Tic Disorder	☐	☐		☐	☐
Psychotic Disorder	☐	☐		☐	☐
Bipolar Disorder	☐	☐		☐	☐
Depressive Disorder	☐	☐		☐	☐
Anxiety Disorder	☐	☐		☐	☐
Obsessive-Compulsive Disorder	☐	☐		☐	☐
Trauma- or Stressor-Related Disorder	☐	☐		☐	☐
Dissociative Disorder	☐	☐		☐	☐
Feeding or Eating Disorder	☐	☐		☐	☐
Substance Related or Addictive Disorder	☐	☐		☐	☐
Neurocognitive Disorder	☐	☐		☐	☐
Personality Disorder	☐	☐		☐	☐
Other:	☐	☐		☐	☐

Other Family Conditions that May Affect Clinical Treatment:

☐ Relational ☐ Educational ☐ Occupational ☐ Housing ☐ Financial ☐ Social ☐ Criminal / Legal

Please describe above in further detail:

Family Medical					
Diagnosis:	**Yes:**	**No:**	**Who?**	**Current?**	
				Yes:	**No:**
Acid Reflux	☐	☐		☐	☐
Asthma	☐	☐		☐	☐
Autoimmune Disorder	☐	☐		☐	☐
Birth Defect / Congenital Anomaly	☐	☐		☐	☐
Diabetes	☐	☐		☐	☐
Food Allergies	☐	☐		☐	☐
Genetic Disorder	☐	☐		☐	☐
Hearing Disorder	☐	☐		☐	☐
Irritable Bowel Disorder	☐	☐		☐	☐
Migraine / Headaches	☐	☐		☐	☐
Scoliosis	☐	☐		☐	☐
Seizure Disorder	☐	☐		☐	☐
Tuberculosis	☐	☐		☐	☐
Vision Problems	☐	☐		☐	☐
Other:	☐	☐		☐	☐

Documents Requested:

- **Health Insurance Card**
- **Psychological Diagnostic Report**
- **Educational Reports**
- **Other Treatment Provider Reports**
- **Legal Custody Agreement (if applicable)**