

Child's name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Form completed by \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Date completed \_\_\_\_\_

Please summarize your concerns:

When did these problems begin?

What are your goals for this consultation?

School:

Name of school:

Grade:

Please describe your child's strengths and challenges in the classroom. Include any services that are provided and a copy of the IEP or any testing that has been completed if applicable.

What concerns have the teachers mentioned and how have they tried to address these concerns?

Behavior:

Work completion/homework:

Academic progress:

Handwriting/neatness:

Careless mistakes:

Distraction/attention:

Other:

Were there concerns mentioned by prior teachers?

Home:

Please describe concerns that you have about your child at home:

Overall mood:

Homework:

Chores:

Listening:

Relationship with parents/Siblings:

Discipline strategies you utilize:

With whom does your child live? Siblings/ages?

Current after school care arrangement:

Parents married? Divorced? What are custody arrangements? Do the parents have a good relationship with one another?

What are the family stressors?

Social:

Describe any concerns you have about your child's ability to make and keep friends or any aspects of your child's relationships that concern you.

Confidence/Self Esteem:

Describe any concerns you have in this regard:

What does your child do that he/she feels good about?

What organized activities does your child participate in? (music, sports, religion)

**Please complete the next section regarding past medical and family history.** If you feel that some of the information has been reviewed recently with you clinician, you may make a note to refer to the chart at your discretion. Please note any additional information that you feel may be helpful even if not specifically requested.

Have you or your child's M.D. or nurse practitioner had any concerns about:

Development:

Growth:

Weight loss or gain:

Head size:

Speech or understanding of language:

Memory:

Appetite:

Sleep:

Headaches:

Stomach aches:

Tics:

Fainting:

Chest Pain:

Trouble Breathing:

Day or night stool or urine accidents:

Constipation or diarrhea:

Hair loss:

Skin changes:

Pain: (where, when)

Other:

List any chronic or serious current or past medical concerns, include dates and medications where able:

Hospitalizations or Surgeries:

Current medications:

Allergies to medications, foods, pollens etc.:

Additional family history: (include parents, siblings, grandparents, aunts, uncles and cousins)

Learning problems:

Behavior problems: (such as hyperactivity, trouble in school, trouble with the law, high school drop out):

Mental health concerns: (depression, anxiety, Obsessive compulsive, suicide attempt or completion, psychiatric hospitalization, mental retardation, other)

Chemical dependency or abuse:

Difficulty holding a job:

Please feel free to add other concerns that may not have been covered:

Best way to reach parents with questions or concerns:

