Sandy Springs Psychological Center, P.C.

Judy D. Wolman, Ph.D.
Director

BACKGROUND INFORMATION: Date: _____

Child's Name: _____

Date of Birth: _____ Chronological Age: _____

School: _____ Grade _____

Parent 1 Name: _____

Address: _____

_____

Home Telephone: _____ Work Telephone: _____

Cell Phone: _____ Email: _____

Occupation: _____

Parent 2 Name: _____

Address: _____

_____

Home Telephone: _____ Work Telephone: _____

Cell Phone: _____ Email: _____

Occupation: _____

Step-Parent/Guardian Name: _____

Address: _____

_____

Home Telephone: _____ Work Telephone: _____

Cell Phone: _____ Email: _____

Marital Status of Parents: Single ____ Married ____ Divorced ____ Widowed ____ Other ____

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REFERRAL INFORMATION:

Referred By: _____

Describe the reasons you are requesting this evaluation of your child. If possible, list specific questions for which answers are sought.

_____

_____

_____

Language(s) spoken if not English: _____

List all people now living in your household, then draw a line and list others who have previously lived with the child. (Please note dates)

NAME	RELATIONSHIP TO CHILD	AGE	HIGHEST SCHOOL GRADE ATTENDED	OCCUPATION

Please indicate if any children in the household were adopted and dates of any previous marriages, divorces, or remarriages of Parents. Describe any custody arrangements or other living arrangements/situations. Describe any deaths in the immediate family. Note any unusual family circumstances.

_____

_____

_____

_____

_____

_____

Pediatrician: _____

Address: _____

_____

Telephone: _____

Permission to speak with pediatrician: Yes _____ No _____

PREGNANCY AND BIRTH HISTORY:

Describe any complications that occurred during pregnancy

_____

_____

_____

Describe any complications that occurred during delivery (i.e., prematurity, postmaturity, length of labor, special procedures, etc.)

_____

_____

_____

Birth weight? _____ How long after birth did you take your baby home? _____

EARLY TEMPERAMENT:

Describe the child's temperament during the first 6 months (i.e., sleep patterns, colic, eating patterns)

_____

_____

_____

_____

DEVELOPMENTAL HISTORY: (Note the approximate ages of the following:)

Sitting unsupported: _____ Walking independently: _____

Using single words: _____ Using two or more words together: _____

Toileting: Urine daytime: _____ Nighttime: _____

Bowel daytime: _____ Nighttime: _____

Which hand does your child prefer? Right _____ Left _____ Age established _____

MEDICAL HISTORY:

List sicknesses (i.e., frequent ear infections, operations, and injuries). Include the age when they occurred and severity. Please pay special attention to head injuries, any loss of consciousness, convulsing, or very high fever.

_____

_____

_____

_____

_____

Did anyone in your immediate family or close relative have any of the following?

Nervous tics?	Yes _____	No _____	Who? _____
Seizures (epilepsy)?	Yes _____	No _____	Who? _____
Emotional problems?	Yes _____	No _____	Who? _____
Hyperactivity?	Yes _____	No _____	Who? _____
Learning problems?	Yes _____	No _____	Who? _____
Language problems?	Yes _____	No _____	Who? _____
Cognitive deficits?	Yes _____	No _____	Who? _____
Similar problems to child?	Yes _____	No _____	Who? _____

Does any disease run in the family? If so, what? _____

Concussions

Please list dates of any concussions, severity, and treating physician

How long was your child out of school? When was your child cleared to return to school?

Does your child experience any ongoing symptoms?

Past medications: (indicate year, dosage, physician, and reason it was taken):

Current medications:

Medicine: _____ Dose: ___ Purpose: _____ Prescribed By: _____

Medicine: _____ Dose: ___ Purpose: _____ Prescribed By: _____

Medicine: _____ Dose: ___ Purpose: _____ Prescribed By: _____

Medicine: _____ Dose: ___ Purpose: _____ Prescribed By: _____

Has your child's vision been examined?_____ Date: _____

If so, by whom? _____

Results: _____

Has your child's hearing been examined?_____ Date: _____

If so, by whom? _____

Results: _____

Other special medical tests (EEG, CAT Scan, MRI):

Name of Test: _____ Date: _____

Purpose/Results: _____

Previous psychological or neurological evaluations: (List names of providers, addresses, dates, and any pertinent results). **PLEASE PROVIDE A COPY OF THE WRITTEN REPORT.**

_____

_____

_____

_____

Psychiatric hospitalizations: (List names of facilitities, addresses, dates, etc.)

_____

_____

_____

Psychotherapy: (List names of therapists, addresses, dates, etc.)

_____

_____

_____

SOCIAL-EMOTIONAL/BEHAVIORAL HISTORY:

List your child's personality characteristics, both positive and negative:

Note any particular behavioral concerns (i.e., eating habits, sleeping patterns, level of activity, sibling relationships, peer relationships, moodiness, attending difficulties, destructiveness, unusual habits, fears, tenseness, etc.):

Current discipline techniques:

Who disciplines?

Do parents agree on how to discipline?

How does your child respond to discipline?

SCHOOL HISTORY:

List previous schools attended with grades and dates (include nursery and preschool):

List current teachers and subjects taught: _____

Describe any learning/behavioral/social difficulties at school:

Public School services: (List date placed and services received)

Early Intervention program: _____

TAG/Discovery (Gifted Program): _____

Learning Disability/O.H.I./Student Support Team: _____

Does your child have an IEP or 504 Plan? _____ Yes _____ No **PLEASE ATTACH**

Speech and language services:

Occupational therapy services:

Private services: (List date placed, name of service provider, services received, and phone number)

Tutoring:

Speech/language therapy:

Occupational therapy:

Does your child have a Learning plan/receive accommodations at school? _____ Yes _____ No
PLEASE LIST CURRENT ACCOMMODATIONS AND PROVIDE A COPY OF LEARNING PLAN

Has your child been granted accommodations on the PSAT, SAT, or ACT? _____ Yes _____ No
PLEASE LIST AND INCLUDE A COPY OF ACCOMMODATION LETTER

If your child attends a private school, do they participate in any specialized programs through the school for learning support? If so, describe: _____

_____

_____

Has your child ever repeated a grade? _____ If so, when? _____

What was the reason? _____

_____

ATTACH A COPY OF THE MOST RECENT REPORT CARD AND STANDARDIZED TEST SCORES.

You will receive copies of your child's report to distribute to various school personnel and physicians. If you wish a report of findings to be sent directly from our office to a physician, school, or other child agency, please indicate to whom and sign attached release of information form:

_____

_____

_____

_____

Please feel free to add any additional comments which you feel will be helpful on the attached page.

Payment is expected the first day of the evaluation. The reimbursement by insurance coverage is a negotiation between you and your insurance representative. I do not accept deferred payment by your insurance carrier.

I very much appreciate the trouble to which you have gone in filling out this questionnaire. Please add any additional comments on the next page.

Signed: _____

PLEASE INCLUDE COPIES OF:

- **REPORT CARD**
- **STANDARDIZED TESTING**
- **PREVIOUS PSYCHOLOGICAL REPORTS**
- **IEP/504 PLANS/CURRENT LEARNING PLAN FROM SCHOOL**
- **ACCOMMODATION LETTERS FOR PSAT, SAT, OR ACT**
- **ANY CUSTODY DOCUMENT IN CASE OF DIVORCE**
- **CONCUSSION DOCUMENTATION**

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Authorization Form

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize my psychologist, _____ and/or her administrative and clinical staff, to release/receive information as follows: _____

_____

_____

(Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

This information should only be released to (name and address of person to whom the information is to be released)

_____

_____

I am requesting my psychologist to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

_____

_____

This authorization shall remain in effect until _____(fill in expiration date) or until _____
(fill in an event that relates to the individual or the purpose of the use or disclosure).

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient Date

_____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

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