Philosophy
To create supportive partnerships with families, focus on joyful interactions through play, and to develop customized treatment plans that are strategic, intensive and effective, while meeting the needs of the family.

Instructions
Please fill in as much or as little of this form as you would like before your first meeting. If you prefer to jointly complete with your therapist this information can be taken during the Parent Interview. Copies of any previous therapist, school or doctor's reports that you can provide at the time of our meeting will be greatly appreciated. The information you provide along with the Parent Interview will help us develop a plan together that can support your family and your goals for your child.

ALL OF THE INFORMATION YOU SHARE WITH THE CENTER FOR HOPE & HEALING WILL REMAIN PRIVATE AND CONFIDENTIAL

GENERAL INFORMATION

Child's name: _____ Age: _____ Date of Birth:_____ Gender: M F
Name of person completing this form: _____
Relationship to child: _____
Who referred you? _____
Date form completed: _____

PURPOSE OF EVALUATION

What specific concerns do you have about your child?

Has your child completed an evaluation or received treatment to address these concerns? If yes, when and by whom?

Have you implemented any interventions at home, school, and/or day care to address these concerns?

What are you hoping will be the outcome of our therapy services?

FAMILY INFORMATION

Please list the persons who are currently living in the home with the child:

Name	Sex	Age	Relationship to Child
1._____	___	___	_____
2._____	___	___	_____
3._____	___	___	_____
4._____	___	___	_____
5._____	___	___	_____

Please list any family members who are no longer in the home:

Name	Sex	Age	Relationship to Child	When did they leave?
1._____	___	___	_____	_____
2._____	___	___	_____	_____
3._____	___	___	_____	_____

Mother's name: _____ Age: _____
Work hours: _____
Place of employment: _____

Father's name: _____ Age: _____
Work hours: _____
Place of employment: _____

Parents are (please provide data):

Married _____ Separated ____Divorced _____Unmarried ___ Widowed _____
If parents are divorced, who has legal custody? _____
If parents are separated or divorced, please describe visitation arrangements:
_____
_____
_____

Is this child? Biological _____ Adopted _____ Foster _____

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What languages are spoken in the home? _____
How long has the child been living in the current home? _____
How many times has the child moved in the past 3 years? _____
Who provides care for your child while at work (if applicable)? _____
Please list any current or past stressors that may be or be impacting this child emotionally or socially? (i.e. financial, illness, divorce, etc.): _____
_____
_____
_____

Please list anyone in the immediate extended family with learning difficulties:

Person (parent, sibling, grandparent, uncle, etc.)	Type of Difficulty (language, reading, math, attention, auditory processing, etc.)
_____	_____
_____	_____
_____	_____
_____	_____

Please list anyone in the immediate extended family with behavioral or emotional difficulties:

Person (parent, sibling, grandparent, uncle, etc.)	Type of Difficulty (depression, trouble with law, drug abuse, psychosis, etc.)
_____	_____
_____	_____
_____	_____
_____	_____

Has anyone in the immediate extended family suffered from:

Condition	Person	Describe Problem
Seizures/epilepsy?	_____	_____
Any other neurological disorder?	_____	_____
Mental Retardation	_____	_____
Any genetic disorder	_____	_____

BIRTH INFORMATION

Please list number of: pregnancies_____ live births_____

	Yes	No
Did you receive regular medical care during this pregnancy?	___	___
Did you have any problems during this pregnancy?	___	___

If yes, please describe the problem when it occurred during the pregnancy (such as diabetes, excess vomiting, bleeding, high blood pressure, toxemia, weight loss, fever, accidents): _____
_____
_____

Did you smoke cigarettes during this pregnancy?	___	___
If yes, how many pack a day did you smoke? _____		
Did you consume alcoholic beverages during this pregnancy?	___	___
If yes, how many days per week, on average, did you drink? ____		
Did you take medication during this pregnancy?	___	___

If yes, please list:
1) _____
2) _____
3) _____

Did you carry this baby a full 9 months?	___	___

If no, please indicate the length of pregnancy in weeks? ___

Describe type of labor (e.g., fast, long, easy, hard)? _____
How long did labor last in hours? _____

Were there any problems with the delivery?	___	___

If yes, please describe the problems (emergency Cesarean section, slow heart rate, fever, cord around neck, etc.) : _____
_____
_____

How much did baby weigh at birth? _____

How many days did the baby remain in the hospital? _____

Did your baby require special care shortly after birth?	___	___

If yes, please describe the type of care (oxygen, incubator, blood transfusions, bili ligh-jaundice, medications, etc.) _____
_____
_____

DEVELOPMENTAL INFORMATION

At approximately what age did your child:

Sit without help?	_____	Say single words meaningfully?	_____
Crawl?	_____	Combine two or more works?	_____
Walk without help?	_____	Use sentences?	_____
Toilet trained?	_____	Show hand preference?	_____

Which hand does your child prefer for writing/drawing? _____ eating? _____ sports? _____

Compared to other children, do you feel your child has had any problems with:

YES	NO	ITEM DESCRIPTION	EXPLANATION
___	___	Fussiness as an infant?	_____
___	___	Eating?	_____
___	___	Sleeping?	_____
___	___	Learning to talk?	_____
___	___	Understanding language?	_____
___	___	Unclear speech?	_____
___	___	Building with blocks, playing with puzzles, drawing, etc.	_____
___	___	Gross motor skills (walking, hopping, riding bike, etc.)?	_____
___	___	Fine motor skills (fastening buttons, zippers, drawing, etc.)?	_____
___	___	Toilet-training?	_____
___	___	Bed-wetting?	_____
___	___	Separating from parents?	_____
___	___	Unusual fears?	_____
___	___	Early school-related skills (naming colors, counting, alphabet, etc.)?	_____
___	___	Playing or socializing with other children?	_____
___	___	Unusual habits or routines?	_____
___	___	Sitting still?	_____
___	___	Concentrating?	_____
___	___	Managing frustration?	_____
___	___	Aggression?	_____
___	___	Other difficulties?	_____

MEDICAL INFORMATION

	Yes	No
Has you child ever been hospitalized?	___	___
If yes, please list ages and reasons: _____		
Has your child ever had surgery?	___	___
If yes, please list ages and reasons: _____		
Has your child ever had any head injuries?	___	___
If yes, what happened and when? _____		
Was the child unconscious?	____	____
Was the child dizzy?	____	____
Did the child have a headache afterward?	____	____
Did the child vomit afterward?	____	____
Has your child ever had a seizure or convulsion?	____	____
If yes, please describe, including ages and medication that were prescribed, if any: _____		
Does your child have any allergies?	____	____
If yes, please describe: _____		
Special Diet _____		
Does your child have frequent abdominal pain or vomiting?	____	____
If yes, please describe: _____		
Does your child have frequent or severe headaches?	____	____
If yes, how are they treated: _____		
Does your child have any vision problems?	___	___
Please specify: _____		
Does your child have any hearing problems?	___	___
Please specify: _____		

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	Yes	No
Does your child have a history of frequent ear infections?	___	___

If yes, please describe how often and at what ages: _____
_____

Is your child currently taking any medications?	___	___

If yes, please list: Reason child is taking:

_____ _____
_____ _____
_____ _____
_____ _____

Has your child ever been evaluated by a psychologist, psychiatrist or counselor?	___	___

If yes, please describe reasons, when and by whom:: _____
_____

Has your child ever been given any learning, psychological, or other diagnosis?	___	___

If yes, please specify:: _____
_____

Please list the name, address, and telephone number of your child's primary physician/clinic:

Name: _____

Address: _____

_____

Phone number: _____

SCHOOL INFORMATION

Current school name: _____

Grade placement: _____

School address: _____

_____

Telephone number: _____

Who is the appropriate contact person for details for your child's schoolwork?

_____
(I will not contact this person without your signed consent and permission.)

	Yes	No
Did your child attend preschool? If yes, give ages and attendance dates: _____	___	___
Did your child ever repeat a grade? If yes, which grade(s): _____	___	___
Does your child have an Individualized Education Plan (IEP)? If yes, when was s/he last evaluated? _____	___	___
Does your child have a 504 plan? If yes, why? _____	___	___
Has your child ever received services in a special education classroom? If yes, when and for what reasons (e.g., learning disabilities, emotional problems, mental retardation): _____	___	___

_____
_____
_____
_____
_____

Has your child ever received any of the following?

Service	Yes	No	Ages or Grades
Speech/language Therapy	___	___	_____
Physical Therapy	___	___	_____
Occupational Therapy	___	___	_____
Learning Disabilities tutoring	___	___	_____
School Counseling	___	___	_____

Over the years, how have teachers generally described your child?

_____
_____
_____

What is the typical range of grades/marks your child receives on his or her report card (e.g., from A to C; B to D, etc)?

_____

On average, how much time does your child spend on homework each day?

_____

Describe what type of support your child typically needs to complete homework?

_____
_____
_____

DESCRIPTION OF CHILD

What do you consider your child's best qualities or strengths?

_____
_____
_____

What do you consider your child's weaknesses?

_____
_____
_____

Does your child prefer to play with older, younger, or same age children?

_____
_____
_____

Describe how your child typically gets along with his or her peers?

_____
_____
_____

What activities does your child enjoy when not at school?

_____
_____
_____

When does your child require extra support? Please circle

Morning Routine: getting dressed eating breakfast transition to car, public transportation, or school bus

School Day: transitions circle/group times centers/free play waiting in line following multi-step directions organizing materials in desk academics snack time lunch time recess

Extra curricular activities: play dates finding appropriate community and recreation programs for your child to participate in (ex: scouting programs, sports, music lessons, art classes, swim lessons) summer camp managing my child's therapy schedule with my work or other children's schedules

Evening Routine: homework playing with siblings dinner time bath time brushing teeth going to bed falling asleep waking in the night giving siblings enough attention or support

Weekends: family downtime finding time to play find ways to spend time inside in winter giving siblings enough attention or support develop weekend schedule/routines attend siblings recreational activities attend birthday parties, large social gatherings, family events participate in religious activities (ex: attending services, religious school, social functions)

Toilet training: not ready yet need help getting started working on it already trained

What is the best time of day for your family at home?

What is the hardest time of day for your family at home?

What is the best part of your child's day at school?

What is the hardest part of your child's day at school?

What is your child's favorite activity to do alone? (ex: play with trains, dress-up, look at books, blocks)

What is your child's favorite activity to do with your family?

What is your child's favorite TV show, character, and/or book?

Is there any other information you would like to share about your child, your family, or what you would like to have additional support with?

Thank you for taking the time to complete this questionnaire. We respect that this process is very lengthy but necessary to understanding your child in his environment. I look forward to working with you.

Signature of parent/guardian: _____

Address: _____

_____

Home Telephone: _____

Work Telephone: _____