

Paradigm Psychological Center
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Licensed Psychologist PSY 21818
Assessment: Students/Adults

General Information

Student Information

Today's Date: _____

- Student's Name: _____ Gender: _____ Age: _____ DOB: _____
- Home Address: _____ City: _____
- Zip Code: _____ Home phone: () _____
- Application completed by: _____ e-mail address: _____
- Please describe the nature of this student's difficulties: _____

- School presently attending: _____ Current grade: _____
 - Phone: () _____ Date started: _____ Teacher: _____
- € → **I have received and agree with the informed consent:** ___ No ___ Yes

Referral Information

- Referred by: _____ Phone number: () _____
- Address: _____ City: _____ Zip Code: _____

Parent Information

- **Mother:** Name: _____ Home phone: () _____
- Address (if different from above): _____
- City: _____ State: _____ Zip code: _____
- Employer: _____ Cell phone: () _____
SSN: _____ Mother's Date of Birth: _____

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- **Father:** Name: _____ Home phone: () _____
 - Address (if different from above): _____
 - City: _____ State: _____ Zip code: _____
 - Employer: _____ Cell phone: () _____
SSN: _____ Father's Date of Birth: _____

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- **Step-Parent:** Name: _____ Home phone: () _____
 - Employer: _____ Cell phone: () _____
SSN: _____ Date of Birth: _____

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- **Step-Parent:** Name: _____ Home phone: () _____
 - Employer: _____ Cell phone: () _____
SSN: _____ Date of Birth: _____

Psychosocial History

Parents

- Education level of Mother: _____ Occupation: _____
- Mother's ethnicity:
____Caucasian ____African American ____Hispanic ____Asian/Asian American
____Native American ____Other: _____
What culture does Mother identity with? _____
Mother's religious affiliation: _____
Level of spirituality: _____

- Education level of Father: _____ Occupation: _____
- Father's ethnicity:
____Caucasian ____African ____Hispanic ____Asian/Asian American
____Native American ____Other: _____
What culture do you identity with? _____
Father's religious affiliation: _____
Level of spirituality: _____

Annual Family Income: \$ _____
If parents are separated or divorced: Date: _____ Student's age: _____

- Student's reaction: _____
What are the current legal custody arrangements? ____Joint legal ____Other, _____
What is the current living and visitation arrangement? _____
Is a parent deceased? ____No ____Yes If yes, please describe: _____
- Was the student adopted? ____No ____Yes If yes, student's age at adoption _____
Are there any family problems or recent changes that you feel might be contributing to this student's difficulties? ____No ____Yes If yes, please describe: _____

Siblings

- Please list all siblings (including step-siblings), current ages, and gender:
1. _____ 3. _____
2. _____ 4. _____

Family Relationships

- Please describe this student's relationship with:
Mother: _____
Father: _____
Siblings: _____
Others: _____

- Please describe the parenting styles of each parent:

- At present, what behavior is the most difficult for you to handle? _____
- How do you and your spouse handle discipline issues? _____
- How much supervision does this student need?
____More than peers ____About the same as peers ____Less than peers

Developmental History

Pregnancy

• Mother's overall health during pregnancy: _____

• Was mother exposed to any infectious diseases (e.g., rubella, syphilis, AIDS, toxoplasmosis) during the pregnancy?
___ No ___ Yes

Medications used by mother during pregnancy:

___ None

___ Prescription medications, Name: _____

___ Non-prescription medications, Name: _____

___ Caffeine ___ Tobacco ___ Alcohol ___ Other: _____

Mother's diet during pregnancy: ___ Good ___ Average ___ Poor

• Did mother take daily vitamins during her pregnancy? ___ No ___ Yes

Medications used by father 6 months prior to pregnancy:

___ None

___ Prescription medications, Name: _____

___ Non-prescription medications, Name: _____

___ Caffeine ___ Tobacco ___ Alcohol ___ Other: _____

Father's diet prior to pregnancy: ___ Good ___ Average ___ Poor

Was the father's exposed to high amounts of teratogens such as radiation, lead, or pesticides prior to pregnancy? ___ No ___ Yes

Birth

Mother's age at delivery: _____ Any labor or birth complications: _____

___ Premature, weeks early: _____ ___ On Time ___ Late, weeks late: _____

___ Evidence of fetal distress: _____

Was the baby taken away following delivery? ___ No ___ Yes

Was the baby allowed to nurse following delivery? ___ No ___ Yes

Father's age at delivery: _____

Sensory Functioning

Are you aware of any problems your child has processing sensory information (e.g., visual, auditory, touch, taste, smell)? If yes, please explain: _____

Does your child have synesthesia? ___ No ___ Yes. Synesthesia is the involuntary stimulation of one sensory modality reliably causes a perception in one or more different senses? For example, letter/numbers may have colors (e.g., the letter "A" may be red), a person might describe the color, shape, and flavor of someone's voice, music has a shape to it, or a scent is associated with a color.

Is your child "hypersensitive" to, or does it cause your child undue stress/anxiety, when s/he encounters:
___ light touch ___ sudden movement ___ high frequency noises

___ excessive noise ___ excess of visual stimuli ___ certain smells ___ certain foods/tastes

Early Development

Did the baby “nestle”? No Yes

Did the baby prefer separate space to being held? No Yes

Did the baby prefer to be tightly wrapped or “swaddled”? No Yes

Was the baby’s cry soothed when: ...fed? No Yes ...held? Yes ...changed? No Yes
...bathed? No Yes ...rocked? No Yes

Was the baby breast fed? No Yes

Were there *feeding problems*? If yes, please describe: _____

• Did the baby sleep in a separate crib? No Yes

Was the crib in the same room with mother? No Yes

What was the *general temperament* of this student during the early years?

Easy, adaptable Withdrawn, slow to adapt Difficult, intense reactions Colicky

• Did the baby attach to the primary caretaker? No Yes

Who was the primary caretaker? _____

Would you consider the *early attachment* between mother and baby: Strong Moderate Weak

• How would you describe this student’s early *sleeping patterns*?

Regular and predictable Irregular and unpredictable

Required very little sleep Required much sleep

• How would you describe this student’s early *feeding patterns*?

Regular and predictable Irregular and unpredictable

Required little food Required much food

What was this student’s early *general activity level*?

Hyperactive Active Average Low energy Lethargic

In general, was this student: Easy to care for Difficult to care for

• How did this student respond to *changes in routine* or to *transitions*?

Easy, adaptable Withdrawn, slow to adapt Difficult Crying/Screaming

Did *toilet training* present any difficulties? No Yes If yes, please describe:

• Was this student exposed to *physical abuse*? No Yes

• Was this student exposed to *emotional abuse*? No Yes

• Was this student exposed to *sexual abuse*? No Yes

Was this student exposed to any traumatic events? No Yes, what: _____

• Please describe any other *significant events* during this student’s early years (e.g., postpartum depression, illness, trauma, moves, marital difficulties) and their impact on this student:

• Age when you noticed that something was not quite right with you, the child? _____

• What were the first symptoms you noticed that concerned you?

• Has your child’s functioning declined in any area? If yes, please describe:

Language Development

During the first year of life, other than crying, would you say that this student was a:
___ Silent or very quiet baby ___ Very noisy baby ___ Verbally interactive baby

- How was this student's language development? ___ Consistent ___ With significant breaks
First spoken words: ___ Early ___ Typical ___ Late
First spoken sentences: ___ Early ___ Typical ___ Late

- Does this student have any trouble:

Making certain speech sounds? ___ No ___ Yes

Understanding language? ___ No ___ Yes

Describing events and/or telling a story coherently? ___ No ___ Yes

Hearing subtle differences in words (e.g. pin/pen)? ___ No ___ Yes

Tended to use somewhat odd phrases? ___ No ___ Yes

Tend to repeat the same phrase over and over? ___ No ___ Yes

Engage in "small talk" or use language primarily to participate in a social interchange? ___ No ___ Yes

Participate in reciprocal conversation with peers? ___ No ___ Yes

Use socially inappropriate questions or statements? ___ No ___ Yes

Sometimes use words that are odd or made up? ___ No ___ Yes

Regularly talk outloud to him/herself? ___ No ___ Yes

Uses inappropriate volume, rate, or pitch in speech? ___ No ___ Yes

Have difficulty communicating with other's his/her own age? ___ No ___ Yes

Overall, do you feel that this student's language development was: ___ Slower than peers

___ About the same as peers ___ Ahead of peers

Student's primary language: ___ English ___ Other: _____

Languages spoken in the home: ___ English ___ Other: _____

Motor Development

Sitting alone: ___ Early ___ Typical ___ Late

Crawling: ___ Early ___ Typical ___ Late

Standing alone: ___ Early ___ Typical ___ Late

Walking alone: ___ Early ___ Typical ___ Late

Does this student have difficulty with *gross motor tasks*, e.g. balancing, hopping, running?

___ No ___ Yes If yes, please explain: _____

- Do you have concerns about this student's *fine motor* abilities, e.g. cutting, eating, or writing?

___ No ___ Yes If yes, please explain: _____

Overall, do you feel that this student's motor development was:

___ Slower than peers ___ About the same as peers ___ Ahead of peers

Medical History

Physician/Pediatrician

• Name: _____ Address: _____

• City: _____ Zip: _____ Phone: () _____

Other Professionals

• Type of Service: _____

• Name: _____ Address: _____

• City: _____ Zip: _____ Phone: () _____

• Type of Service: _____

• Name: _____ Address: _____

• City: _____ Zip: _____ Phone: () _____

Health Record

- Date of last physical: _____
- Please describe this student's current health: _____

• Does this student have any health problems that need to be addressed? _____

Please rate this student's overall diet: ___ Good ___ Average ___ Poor

- Hearing: ___ Normal ___ Below average ___ Wears aid Date of last check: _____
- Vision ___ Normal ___ Below average ___ Wears glasses Date of last check: _____
- Current height: _____ Current weight: _____
- How many cups of caffeinated beverages does your child drink a day? _____

Medications

• Please list any prescription medications this student is currently taking (e.g., stimulants, anti-depressants, tranquilizers, painkillers): _____

• List any medications this student child has taken regularly in the past: _____

Conditions

• Has this student ever suffered from any of the following? (*check all that apply*)

Condition:	When?	Comments:
___ Accidents		
___ Allergies		
___ Asthma		
___ Ear Infections		

___Head Injuries

___Hospitalizations

___Neurological Sxs

___Other Injuries