THE spectrum CENTER LLC.

Testing and Counseling services for the autism, gender, ADHD and learning diversity spectrums

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Demographics and contact information:

Child/Teen's Name: _____ Gender & pronouns: _____

Date of Birth: _____ Age: _____ Grade: (if applicable) _____

How do you describe your child's racial background:_____

What languages does your family speak:_____

Parent1 Name:_____ Relationship to child: _____

Home phone number: _____ Address:_____

Cell phone number: _____ _____

Email for Parent1: _____ _____

Preferred contact: (circle) Home Cell Email May I leave a message on your v-mail? YES NO

Parent2 Name:_____ Relationship to child: _____

Home phone number: _____ Address: same as above or _____

Cell phone number: _____ _____

Email for Parent2: _____ _____

Preferred contact: (circle) Home Cell Email May I leave a message on your v-mail? YES NO

Which is the child's primary address: Parent1 OR Parent2 OR single household

Emergency Contact if parent not available:

Name: _____ Phone Number: _____

Relationship to child: _____

ALLERGIES:

Medication:_____

Food: _____

Environmental/seasonal: _____

For psychologist use only

Marital Status of Parents: ___Married ____Widowed ____Separated ____Divorced ____Never Married

Legal Guardian(s): _____

If parents not currently Married, is there legal custody agreement? ____Yes ____No

Custody agreement or court order provided?_____

If more than one parent has custody, do both agree to evaluation and or treatment? ___Yes ___No

Primary Doctor: _____ Dr. Address: _____

Dr. Phone #:_____ _____

_____

Specialist1: _____ Specialist's Address: _____

Specialist's Phone #: _____ _____

Hospital/clinic association: _____ _____

Specialist2: _____ Specialist's Address: _____

Specialist's Phone #: _____ _____

Hospital/clinic association: _____ _____

What are you seeking help for?_____

_____

_____

What are your child's strengths? What are they good at: _____

_____

_____

Chief Concern(s) *(check any that apply)*

____ Learning problems with reading
____ Completion of school work
____ Aggressive Behavior
____ Daydreaming
____ Temper tantrums
____ Low self-esteem
____ Comprehending things said to child
____ Mood swings/variability
____ Substance use/abuse
____ Smoking
____ Harm another child
____ Intense Fears or phobias (Please explain): _____

____ Learning problems with math
____ Failing grades/poor academic performance
____ Getting along with siblings
____ Getting along with others
____ Depression
____ Anxiety
____ Saying what they want to say
____ Sleeping difficulties
____ Eating difficulties
____ Fire setting: (freq/locat./intent)_____
____ Harm/injure/cruel to family pet or other animal

_____

Chief Concern(s) continued *(check any that apply)*

____ Attention Difficulties (Please explain): _____

_____

____ Significant change in behavior (Please explain): _____

_____

Other: _____

Risk factors: *(check any that apply)*

____History of self-injurious behavior (Describe) _____

_____

___Previous suicide attempt/ideation (Describe)_____

_____

___Current suicidal ideation (Describe) _____

_____

___ Any sexual behavior placing child/teen at risk (Describe) _____

_____

___ Any guns or other weapons in the home or other places the child spends time? How are they secured?

_____

Social and Family History

The child lives with: [ ] Biological parent(s) [ ] Adoptive parent(s) [ ]Foster parent(s) Other _____

Since birth, how many homes has your child lived in? _____

Reasons for moving? _____

Parent1's name: _____ Date of Birth/Age: _____

Highest level of Education: _____

Occupation: _____

Place of Employment: _____

Is Parent1 living in the home? _____

Amount and type of contact with child: _____

Parent2's name: _____ Date of Birth/Age: _____

Highest level of Education: _____

Occupation: _____

Place of Employment: _____

Is Parent2 living in the home? _____

Amount and type of contact with child: _____

Child's brothers and sisters (Please list beginning with the oldest)

Name	Age	Living at Home?	School/Grade

List others living in the home: _____

_____

Have there been any upsetting events at home? _____

_____

or with friends?_____

_____

Is there any NJ DCP/ PA DHS or other legal involvement for the family (divorce, custody hearing, school suit)?

_____

_____

Does your child prefer to associate with (circle most common): older people; younger people; the same age

Does your child make friends easily? _____

Does your child have difficulty keeping friends? No Yes why?: _____

_____

Does your child have many friends? _____

In the neighborhood? _____ In school? _____ Organized activities? _____

How does your child get along with others in the family?

Parents? Yes No Explain: _____

Siblings? Yes No Explain: _____

How is your child disciplined? _____

_____

_____

Religious Affiliation/Spirituality Relevance to current problem(s)

Child and/or family spiritual/religious tradition(s): _____ □ Resource □ Stressor
Local religious affiliation (church, synagogue, etc): _____ □ Resource □ Stressor

Cultural beliefs/needs to be considered (ex: dietary restrictions, religious calendar, religious practices): _____

_____

Medical History

Prenatal & Neonatal History:

Mother's health during the pregnancy: Excellent _____ Good _____ Fair _____ Poor_____

Any illnesses or complications during the pregnancy? (Explain) _____

_____

List any prescribed medications taken during pregnancy: _____

_____

List any prenatal exposure to alcohol/street drugs/nicotine: _____

_____

Length of Pregnancy: _____ weeks Labor: _____hours
Type of Delivery: Vaginal _____ Cesarean_____

Birthweight: _____pounds _____ ounces Breech presentation? _____

Complications (if any): _____

_____

Condition at birth: _____

NICU care?: No Yes: length of stay:_____ Jaundiced? No Yes: light therapy - No Yes

Oxygen needed? No Yes Incubator? No Yes Transfusion Needed? No Yes

Length of hospital stay: Infant: _____days Mother: _____days

Previous pregnancies? *(circle one)* No Yes

Any complications? *(circle one)* No Yes , please explain: _____

Childhood Medical History

Medication Name	Current	Past	Daily Dose	Ages of Treatment	Effects

Please check all the illnesses/conditions that the child has had:

_____ Asthma
_____ Ear Infection #:___
_____ Convulsions/Seizures
_____ Encopresis (Bowel problems)
_____ Enuresis (bed/pants wetting)
_____ Diabetes
_____ Lead level concern
_____ Loss of Consciousness
_____ Head injury/Concussions
_____ Headaches
_____ Body aches
_____ Sexually Transmitted Infections, specify: _____
_____ Epilepsy
_____ Ear/hearing problem
_____ Meningitis
_____ Stomach aches
_____ GI problems

Please explain any areas checked above in detail _____

_____

_____

_____

Tubes in ears? _____ Which Ear(s)? Both or Left / Right When? _____

Date of last vision screen? _____ Date of last hearing screen?_____

Other serious illness or injury? (Describe): _____

_____

_____

_____

Any hospitalizations? No __ Yes____ When? _____

What for? _____

Any surgeries? No __ Yes____ When? _____

What for? _____

Is your child sleeping: *(circle one)* Regularly or Irregularly , explain: _____

_____

Does your child sleep alone in their own bed? Yes or No, where?_____

Is your child eating: *(circle one)* Regularly or Irregularly, explain: _____

_____

Has your child had any Labs, x-rays, genetic testing, or other special tests? _____

_____

_____

_____

Family Medical History

Any relatives with special needs like autism or intellectual disability/MR? _____

_____

Any family members with congenital abnormalities/birth defects? _____

_____

Any deaths within the immediate family (including infants)? _____

_____

List any mental health problems within the family. _____

_____

List any family members with alcohol and/or other substance abuse issues. _____

_____

Describe any other medical problems within the family that may worry the child or interfere with caregiving.

_____

_____

Childhood Behavioral Health Treatment History:

□None
□ Out-Patient Psychotherapy
□ Out-Patient Medication Management
□ Behavioral Health Rehabilitation Services (aka "Wrap-around")
□ School-Based Behavioral Health Services (one to one or aide)
□Partial Hospitalization (approximate # _____ of days)
□ Inpatient Hospitalization
□ Residential Treatment Facility

Dates	**Provider/Agency**	**Reason**	**Outcome**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If currently in outpatient treatment identify provider, frequency, and date last seen: _____

_____

Substance Use History (10 and older)

Substance	Current Use (Y or N)	Date of Last Use	Freq. of Use	Typical amount used

For any substance listed above not currently used, why did the child/teen stop using? _____

_____

Problems related to substance use:
____ Interpersonal/family ____ Work ____ School ____ Legal

Please describe any problems noted above: _____

_____

_____

Past treatment for substance use (including 12 step programs)

Provider	Approximate Dates	Outcome

Developmental History

Early Development:

Who was the primary caretaker when the child was an infant? _____

Were there any long separations from the main caregiver? No Yes *(Explain)* _____

_____

Were there any early feeding problems? (Allergies to milk/formula)?) _____

_____

At what age did the child: Sit without support? _____ Crawl? _____
Stand? _____ Walk?_____
Speak first word? _____
Speak in phrases? _____
Dress/undress self? _____

Describe any problems with speech/language: _____

_____

At what age was toilet training initiated? _____ Completed? _____

Any accidents after that? *(circle one)* No, not at all Yes, but only occasional Yes, often

Early Personality:
Was the child: *(circle all that apply)* colicky smiley friendly affectionate fussy

Current Development/Capabilities:

Does your child: ***(circle Yes or No for each one)***

Dress/undress their self	Yes	No	Follow 2 step commands	Yes	No
Imitate phrases	Yes	No	Smile back and forth	Yes	No
Speak in sentences	Yes	No	Wave	Yes	No
Turn to name	Yes	No	Point	Yes	No
Follow 1 step commands	Yes	No	Show others their toys	Yes	No

To your knowledge, has your child experienced any of the following?:
Physical abuse ____Yes ___No
Emotional abuse ____Yes ___No
Sexual abuse ____Yes ___No
Bullying ____Yes ___No
Any other frightening event (fire, accident, natural disaster, serious injury? ____Yes ___No

If yes to any of the above, describe the nature, intensity and impact of the abuse: _____
_____

_____

_____

Educational History:
Does/did your child receive early intervention services through NJEIS or PA ChildLink (birth – 3)? Yes No

Does/did your child receive preschool special education through a NJ school or PA Elwyn (3 – 5)? Yes No
Does/did your child attend a specialized preschool? Yes No

Early Interventions: (*Mark all locations that apply)*

Speech Therapist	School [ ]	Home [ ]	Outpatient – Provider _____
Occupational Therapist	School [ ]	Home [ ]	Outpatient – Provider _____
Special Instructor	School [ ]	Home [ ]	Outpatient – Provider _____
Physical Therapist	School [ ]	Home [ ]	Outpatient – Provider _____
Other: _____	School [ ]	Home [ ]	Outpatient – Provider _____

Preschool:
Does/did you child attend preschool or daycare outside the family home? Yes No

1) Name:_____Dates:_____

2) Name:_____Dates:_____

Prior School History:

School: _____ Grades attended: _____ IEP/504 services? □ No

□ Yes

School: _____ Grades attended: _____ IEP/504 services? □ No

□ Yes

Current Educational Setting:

School: _____ School phone number:_____

Grade: _____ Current teacher: _____

What is your child's current educational placement? *(choose one)*

_____ Regular education, no special educational supports

_____ Inclusive classroom

_____ Specialized classroom *(circle)* Multi. Disab. Autism Support Emotional Support

Learning Support Life Skills Curriculum/ID

_____ Other (specialized school), explain: _____

Has your child had previous developmental or educational testing? Yes No
Explain: _____

_____

Describe your child's attitude and motivation for school: _____

_____

Explain any current school problem(s) and any previous difficulties: _____

_____

_____

Was your child expelled from or asked to leave any daycare or school placement? No Yes, why_____

_____

_____

ANY OTHER IMPORTANT INFORMATION: _____

_____

_____

_____

_____