



Name: _____ Date: ____/____/____

Name of person completing form and relationship to the patient: _____

Date of Birth: ____/____/____ Date of accident, injury, or onset of symptoms: ____/____/____

Age: ____ Gender: M F Handedness: Left Right

Race/Ethnicity _____ Primary Language (if not English): _____

Referring Physician: _____ Primary Care Physician: _____

Medical Diagnoses (if any): _____

Briefly describe the current concerns: _____

Is there anything that helps reduce the symptom(s)? If so, please describe: _____

Is there anything that seems to worsen the symptom(s)? If so, please describe: _____

Is any treatment being received? If so, with whom and is it helpful: _____

SYMPTOMS AND CONCERNS

Please check each symptom that applies and add any comments as needed.

Cognitive Concerns

Attention and Concentration

- Difficulty paying attention
- Difficulty maintaining concentration
- Difficulty doing more than one thing at a time
- Difficulty following instructions or directions
- Being distracted by his/her own thoughts
- Being distracted by noises or the environment
- Being restless or fidgety
- Procrastinating/Avoiding Effortful Tasks

Problem Solving and Organization

- Difficulty solving problems that others could manage
- Difficulty adapting to change
- Difficulty completing an activity in a reasonable time
- Difficulty organizing
- Difficulty thinking as quickly as needed
- Difficulty planning steps for a project

Speech and Language

- Difficulty finding the word he/she wants to say
- Difficulty understanding what others say
- Using the wrong words when speaking
- Difficulty getting his/her speech started

Memory

- Losing or misplacing things
- Forgetting things that happened hours or days ago
- Forgetting things that happened months or years ago
- Forgetting why he/she walked into a room
- Forgetting conversations
- Forgetting chores, homework, or other tasks

Academic Skills

- Difficulty understanding what is read
- Difficulty retaining what is read
- Difficulty with spelling, grammar or punctuation
- Difficulty with mental math
- Difficulty with paper and pencil math
- Difficulty with handwriting

Physical Concerns

Sensory Symptoms

- Please check if: Near-sighted Far-sighted Astigmatism
- Double vision Poor peripheral vision Color blindness
- Wear glasses: If so, since what age _____
- Hearing loss Ringing in ears Hearing strange sounds
- Problems with taste: If so, Increased/Decreased sensitivity (**Please circle one**)
- Problems with smell: If so, Increased/Decreased sensitivity (**Please circle one**)
- Problems with touch (e.g., texture sensitivity) _____
- Pain (Describe) _____

Motor Symptoms

- Difficulty with balance Difficulty walking Fine motor difficulties
- Tic or strange movements Muscle weakness Muscle stiffness

Emotional and Behavioral Concerns

Mood/Behavior

(PLEASE CIRCLE ONE IF APPLICABLE)

- | | | | |
|---|----------------|----------------|--------|
| <input type="checkbox"/> Sadness or depression | Mild | Moderate | Severe |
| <input type="checkbox"/> Anxiety or nervousness | Mild | Moderate | Severe |
| <input type="checkbox"/> Anger | Mild | Moderate | Severe |
| <input type="checkbox"/> Oppositionality | Mild | Moderate | Severe |
| <input type="checkbox"/> Sleep problems | Falling asleep | Staying asleep | Both |

Problematic Behaviors

- Lying Stealing Verbal Aggression Physical Aggression
- Truancy Fire-setting Destruction of property Sexual Promiscuity
- Bullying/Fighting Tobacco use Illegal substance use Alcohol use

MEDICAL AND TREATMENT HISTORY

Duration of pregnancy: _____ Your child was born through: Vaginal Delivery Caesarean Section

Birth weight: _____ APGAR scores (if known): ____ & ____

Please indicate if any of the following situations were present during the delivery of your child:

<input type="checkbox"/> Induced labor	<input type="checkbox"/> Breech position
<input type="checkbox"/> Fetal distress	<input type="checkbox"/> Use of forceps
<input type="checkbox"/> Hemorrhaging	<input type="checkbox"/> Cord wrapped around neck

Please indicate if any of the following complications were present during the pregnancy of your child:

<input type="checkbox"/> Excessive vomiting	<input type="checkbox"/> Threatened miscarriage
<input type="checkbox"/> Excessive staining/blood loss	<input type="checkbox"/> Hospitalization
<input type="checkbox"/> Accidents or injuries	<input type="checkbox"/> Toxemia
<input type="checkbox"/> Gestational diabetes	<input type="checkbox"/> Gestational hypertension
<input type="checkbox"/> Smoking/tobacco use	<input type="checkbox"/> Drug use
<input type="checkbox"/> Alcohol use	<input type="checkbox"/> X-rays

Please specify any illness/infection present at birth: _____

Please select the approximate time of the following developmental milestones:

	Early	On Time/Average	Late
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check any of the following problems that your child currently has, or has had in the past:

<input type="checkbox"/> Seizures	<input type="checkbox"/> Migraine headaches
<input type="checkbox"/> Head injury or Concussion	<input type="checkbox"/> Poor motor control or coordination
<input type="checkbox"/> Broken bones from a traumatic event	<input type="checkbox"/> Dizziness or vertigo
<input type="checkbox"/> Asthma	<input type="checkbox"/> Wetting the bed
<input type="checkbox"/> Fever over 104 °	<input type="checkbox"/> Chronic ear infections

Do any family members have significant health concerns/special needs? If so, please explain: _____

Please list any other medical, neurological, or psychiatric conditions that run in the family and the affected family member(s): _____

Please list all current medical/psychiatric problems and medications taken for each problem (if any)

<u>Medication & Dosage</u>	<u>Frequency Taken</u>	<u>Medical Problem</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any food or medication allergies: _____

Please list any surgeries:

<u>Surgery</u>	<u>Month & Year</u>	<u>Results/Success?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY

Mother: Name _____ Age _____ Education _____
Occupation _____

Father: Name _____ Age _____ Education _____
Occupation _____

Step-Mother: Name _____ Age _____ Education _____
Occupation _____

Step-Father: Name _____ Age _____ Education _____
Occupation _____

Parents are: Married Separated Divorced Re-married Deceased
Child is: Biological Adopted Foster

Name of Sibling(s)	Age	Gender	Full, Half, Step, or Adopted	Where do they live?

Were there any unusual problems (physical, academic, psychological) associated with any family members?
 Yes No If yes, describe: _____

Who currently lives with the child? _____

Is there any history of abuse or trauma? If so, please explain: _____

EDUCATIONAL HISTORY

Current School: _____ Grade: _____

Class Placement: Regular _____ Advanced _____ Special Education _____

Has your child ever had an IEP (Individual Educational Plan) or 504 plan? Yes _____ No _____

Please list any grades that were skipped or repeated? _____

Typical grades on report cards? _____

Strongest Subject _____ Weakest Subject: _____

Please check any of the following problems that have been noted by your child’s teacher(s):

<input type="checkbox"/> Reading	<input type="checkbox"/> Behavior
<input type="checkbox"/> Writing	<input type="checkbox"/> Social adjustment (getting along with peers)
<input type="checkbox"/> Spelling	<input type="checkbox"/> Attention/Concentration
<input type="checkbox"/> Arithmetic	<input type="checkbox"/> Organization
<input type="checkbox"/> Science/Social Studies	<input type="checkbox"/> Following directions

Additional problems in school: _____

Please provide any additional information that you feel is relevant to this referral:

Please bring this form with you to your first appointment. All information disclosed is part of your psychological records and thus confidential, as dictated by the Health Insurance Portability and Accountability Act, and the rules and regulations from the State of Florida.