The Levin Center

Juliana Bloom Ph.D.
Licensed Psychologist
Pediatric Neuropsychologist
5971 Brick Court, 2nd Floor East
Winter Park, FL 32792
321.240.9532
jbloom@levincenter.org

PATIENT INFORMATION

Client's name:_____

Date of birth: _____

Age:_____ Sex: Male Female

Name of Person Completing This Form: _____

Relationship to Child: _____

Today's date: _____

Address: _____

Phone: _____

Source of referral: _____

School name: _____

Year in school:_____

PRESENTING CONCERNS

Briefly explain the main concerns that have led you to seek an evaluation or treatment:

_____

_____

_____

How will you use the results of this evaluation/consultation (i.e., personal use, school, tutor, therapist, SAT accommodations)?

_____

_____

_____

Are there any current or expected court proceedings regarding this case? If so, please explain.

_____

_____

_____

CONTACT INFORMATION

1. Parent/Guardian: _____

Relationship to child: _____

Parent/Guardian's address (or same as above): _____

Parent/Guardian's phone: _____ (cell) _____(home) _____(work)

Parent/Guardian's email address: _____

Occupation:

Highest grade of school completed or highest degree received: _____

2. Parent/Guardian:

Relationship to child:

Parent/Guardian's address (or same as above): _____

Parent/Guardian's phone:_____(cell)_____(home)_____
(work)

Parent/Guardian's email address: _____

Occupation:_____

Highest grade of school completed or highest degree received: _____

Preferred Parent/Guardian and method of contact (i.e., Mom Cell):

Can we leave phone messages?_____Yes _____No

Text? _____Yes _____No

Marital status of parents:
____ Married_____Divorced_____Separated_____Never Married

If separated or divorced, who has custody of child? Please explain: _____
_____
_____

Are there stepparents or other adults living in the home? If yes, please provide names and contact information: _____
_____
_____

Other than parents, who has responsibility for the care and education of the child (i.e., grandparent, nanny)?
_____

List names of brothers and sisters and ages.

Name	Age	Relationship to child	Living at home?
			▫ Yes ▫ No
			▫ Yes ▫ No
			▫ Yes ▫ No
			▫ Yes ▫ No

Currently, are there any significant stressors or pressures on the family? If yes, describe below:

FAMILY HISTORY

Please place a check mark by the problems that describe your child's family history.

	None	Mother	Father	Siblings	Other Relative (aunt, uncle, grandparents)
Hyperactivity/Impulsivity					
Attention problems (ADHD, ADD)					
Learning problems (LD in reading, math, writing)					
Nervousness/anxiety					
Depression					
Bipolar/mania					
Schizophrenia					
Other (please describe):					

Has there been **a history** of any of the following in the **child's** or **family's life**?

Trouble with the law?	ÿ No ÿ Yes
Domestic violence?	ÿ No ÿ Yes
Concerns about **child's** drug or alcohol use/abuse?	ÿ No ÿ Yes
Parent drug or alcohol abuse?	ÿ No ÿ Yes
Physical abuse/neglect?	ÿ No ÿ Yes
Sexual abuse?	ÿ No ÿ Yes
Frequent moving?	ÿ No ÿ Yes
Gang involvement?	ÿ No ÿ Yes
Suicide attempts/completion?	ÿ No ÿ Yes

If yes to any of the above items, please describe impact on this child:
_____
_____
_____

PREGNANCY AND BIRTH HISTORY

Mother's age at this pregnancy:_____Number of Pregnancy:_____First____Second_____Third_____
Other

Describe any problems during the pregnancy:
_____
_____

During the pregnancy did the mother:

Drink Alcohol?____Yes____No Smoke?__Yes_____No Use Drugs?____Yes____No

Gestational Age at Birth (i.e., number of weeks of pregnancy): _____

Birth Weight: ____ lbs __oz

How was the child born? ___Vaginal Delivery ___ Cesarean Section

Did the baby breathe on his/her own right away? ___Yes ___No

Were any delivery complications or birth defects noted? ___Yes ___No

If yes, please describe:
_____

Any problems in the first year of life? If yes, please describe:
_____

DEVELOPMENTAL HISTORY

Motor
At what age did the child: Sit Up: _____

Crawl: _____

Walk:_____

Was the child slow to develop motor skills or awkward in comparison to his/her brothers and sisters?

_____No _____Yes

If yes, please describe:._____

Handedness:_____Right ____Left ___Both

Family history of left-handedness?_____No ____Yes
If yes, please list left-handed relatives:_____

Has the child ever had Occupational Therapy (OT) or Physical Therapy (PT)?_____No_____Yes
If yes, please describe reason for concerns and dates of service:

_____
_____
_____
_____

Language
At what age did the child: Speak First Word: _____ Put 2-3 Words Together: _____

Any history of poor sucking, problems chewing, or late drooling?_____No____Yes
If yes, please describe: _____

Any history of speech delays or problems (i.e., difficult to understand, stuttering)?_____No____Yes
If yes, please describe:

_____
_____
_____
_____

Has the child ever had Speech-Language Therapy?_____No____Yes

If yes, please describe reason for therapy and dates of service.

_____

Any language other than English spoken in the home?_____No____Yes
If yes, please describe: _____

Did the child have difficulties learning the alphabet or learning to read?_____No____Yes
If yes, please describe: _____

Has the child ever lost developmental skills in any area?_____No____Yes
If yes, please describe: _____

Toileting
At what age was this child toilet-trained? _____

Were there any significant bed-wetting or daytime urine accidents after toilet training? If yes, please explain:
_____

CHILD HEALTH HISTORY

Has your child experienced any serious accidents or injuries?_____No_____Yes
If yes, please describe: _____

Has your child ever been hospitalized or had surgery?_____No_____Yes
If yes, please describe: _____

Has your child experienced any of the following? Check all that apply. If yes, please describe:

□ Dizziness _____
□ Frequent headaches_____
□ Abdominal Pains/Vomiting_____
□ Concussion/head injury_____
□ Loss of Consciousness_____
□ Tics_____
□ Severe allergic reaction _____
□ Chronic Allergies_____
□ Chronic ear infections_____
□ PE Tube placement_____

□ Vision problems_____
□ Hearing problems_____
□ Seizure/epilepsy_____
□ Asthma_____
□ Other_____

Explain any health problems your child has experienced other than routine illnesses:
_____
_____
_____

Does your child get regular exercise? _____No _____Yes

If yes, please describe (i.e., which activities?):_____

Does your child see a physician regularly? _____No Yes

Is vision and hearing testing up to date?_____No_____Yes Wear contacts or glasses?___No_____Yes

Does your child **currently** take any medications or **ever taken** medication in the past for extended periods? ____No_____Yes

Medication	Date started	Purpose	

SOCIAL/PSYCHOLOGICAL HISTORY

What are your child's favorite activities and past times?
_____
_____

Has your child ever been seen by a therapist or psychologist (private or school)?_____No_____Yes

If yes, please describe (i.e., name of psychologist, reason for visit, dates, and length of services):

_____
_____

Has your child ever been seen by a psychiatrist?_____No_____Yes
If yes, please provide name of psychiatrist, for what purpose, dates, and for how long:
_____
_____

Has your child ever been hospitalized for mental health reasons?_____No____Yes
If yes, please provide name of facility, for what purpose, dates, and for how long:
_____
_____

Have there been any problems in the following areas (check all that apply)?

□ Eating Difficulties
□ Weight loss or gain
□ Sleep Difficulties
□ Difficulties Holding a Pencil
□ Aggression or Anger
□ Anxiety
□ Short Attention Span
□ Depressed or Sullen Mood
□ Impulsivity or Hyperactivity
□ Memory Forgetfulness
□ Noncompliance at Home
□ Noncompliance at School
□ Quick changes in mood
□ Self-Injurious Behavior
□ Bullying
□ Peer Difficulties
□ Suicidal Feelings or Actions
□ Worrying or Nail Biting
□ Behavior Problems
□ Social Difficulties
□ Coping and Adjustment
□ Trauma

Explain any of the items above:
_____
_____
_____
_____
_____

Please describe your child's peer relationships and friendships. Note any concerns you have:
_____
_____

EDUCATIONAL/ SCHOOL HISTORY

Name of **current** school or college/university:

_____Public _____Private _____Home-school _____Private specialty school

School District: _____
Current grade in school: _____

For all schools attended, please list chronologically each school's name, grades of attendance, and description of any problems noted by teachers/parents.

School Attended	For Grades	Problems Noted	Description of Problem
		□ Yes □ No	
		□ Yes □ No	
		□ Yes □ No	
		□ Yes □ No	
		□ Yes □ No	

Currently, has parent/guardian or child's teacher reported problems in the following areas (check all that apply):

- □ Reading
- □ Spelling
- □ Arithmetic
- □ Writing
- □ Attention/Concentration
- □ Behavior (e.g., fighting, impulsivity, etc.)
- □ Social Adjustment
- □ Note-taking
- □ Test-taking
- □ Homework Completion
- □ Study Skills
- □ Other: _____

Has your child **ever** received accommodations or special education services at school (currently or in the past)?

- □ No
- □ Yes

Type of current school placement and services received (check all that apply):

- □ Regular classroom
- □ Learning Support
- □ Special Education
- □ Section 504 Plan
- □ IEP
- □ Self-contained classroom
- □ Other: _____
- □ Tutoring (Describe which subject(s):___)
- □ Don't Know or Not Sure

Type of school placement and services received in past (check all that apply):

- □ Regular classroom
- □ Learning Support
- □ Special Education
- □ Section 504 Plan
- □ IEP
- □ Self-contained classroom
- □ Other: _____
- □ Tutoring (Describe which subject(s):___)
- □ Don't Know or Not Sure

Please describe all accommodations used over the past year (i.e., extra time, note-taker, laptop, etc.):

_____
_____
_____

Please describe all accommodations used in the past and in which grades (i.e., grades 1-3, grades 4-7):

_____
_____
_____

Any grades repeated or skipped?_____No_____Yes

If yes, please describe: _____

Has the child ever been **suspended** or **expelled** from school?

□ No □ Yes If yes, please provide details (date/grade in school, reason for suspension/expulsion):_____

If available, please provide SAT/ACT scores:

SAT:_____Reading_____Mathematics_____Writing

ACT:_____English_____Mathematics_____Reading_____Science _____Composite

If child is in the 10th grade or not taken SAT/ACT yet, please provide PSAT/PLAN scores (if available):

PSAT:_____Reading_____Mathematics_____Writing

PLAN:_____English_____Mathematics_____Reading_____Science _____Composite

Please list prior speech-language, occupational, physical therapy, psychological or neuropsychological evaluations (list chronologically). *If available, please bring copies of evaluation with you to your appointment.*

Date	Name/Specialty of Doctor	Place of Evaluation	Diagnosis

CHILD'S STRENGTHS/ADDITIONAL COMMENTS

Please describe your child's strengths and any additional information you consider important:

Please add any additional thoughts or other documentation of the difficulties your child is experiencing.