THE ATLANTA PSYCHOLOGY GROUP
Comprehensive Evaluations for Children & Adolescents

Corbin Feroleto, Ph.D. **Jennifer Foster, Ph.D.**

Emily Bryant, Ph.D. **Julie Cash, Psy.D.** **Fontina Rashid, Ph.D.**

Confidential Questionnaire for Parents

Please return as soon as possible, preferably 5 days prior to assessment.

Name of Child: _____ Date of Birth: _____

Grade:_____ School:_____

Parent Name:_____ Age:_____

Occupation:_____Education:_____

Address:_____

_____

Phone:_____ Email:_____

Parent Name:_____ Age:_____

Occupation:_____Education:_____

Address:_____

_____

Phone:_____ Email:_____

Parents are: ____ Married ____ Cohabitating ____ Separated ____ Divorced

Who has legal custody? _____

Who has physical custody? _____

Describe the reason for referral. If possible, list questions for which answers are sought.

List all people currently living in the household.
Then, draw a line and list others who have lived there during the child's lifetime (e.g., nanny, relative).

Name	Relationship to child	Age	Highest School Grade	Occupation
1.				
2.				
3.				
4.				
5.				
6.				

Please describe if there have been previous marriages, if there have been any deaths in the immediate family, changes in family routine or any incident which may have caused significant emotional stress.

Any family history of:		Which family member (e.g. sibling, mother, father, maternal grandparent, paternal uncle etc)?
____Yes ____No	Speech problems	_____
____Yes ____No	ADHD	_____
____Yes ____No	Learning disability	_____
____Yes ____No	Intellectual disability	_____
____Yes ____No	Behavior problems	_____
____Yes ____No	Dyslexia	_____
____Yes ____No	OCD	_____
____Yes ____No	Tourette's Syndrome	_____
____Yes ____No	Anxiety	_____
____Yes ____No	Depression	_____
____Yes ____No	Suicide	_____
____Yes ____No	Bipolar disorder	_____
____Yes ____No	Other emotional	_____
____Yes ____No	Drug/alcohol abuse	_____

Developmental History

Were there any complications during pregnancy with this child (substance use, weight loss, illness, high blood pressure, spotting, false labor, etc.?) If so, please describe and indicate during which part of the pregnancy the trouble occurred and prescribed medication or treatment. If child is adopted please indicate age at which child was adopted and any known prenatal/developmental history.

Was the baby born premature?_____Late?_____If so, how much?_____
Labor induced?_____Caesarean delivery?_____Length of Labor?_____
Vacuum/Forceps used?_____Breech birth?_____If in incubator how long?_____
Did baby receive oxygen?_____Jaundiced?____Bilirubin lights?_____
Length of stay in hospital: mother?_____child?_____

Please describe any other complications during delivery.

Baby's birth weight_____Apgar score (if known) _____

Describe the baby's condition at birth:

How did the first year go? (colic, feeding, sleeping, etc.) How would you describe your child's temperament once they reached age two?

Developmental Milestones: (If can't recall exact dates, label as WNL for Within Normal Limits or Delayed)

	Age	Comments
Sat alone	_____	_____
Crawled	_____	_____
Stood alone	_____	_____
Walked	_____	_____
Understood first words	_____	_____
Said first word	_____	_____
Use two-word phrases	_____	_____
Spoke in sentences	_____	_____
Toilet trained (day)	_____	_____
Toilet trained (night)	_____	_____

Did your child receive any early intervention (e.g., Babies Can't Wait)? _____

Does your child have any history of sensitivity to: Sound, smell, or texture (e.g., upset by loud noises, avoids certain foods, upset by tags or seams in clothing). If yes, please describe:

Medical History

Name of pediatrician/physician _____
Permission to consult with physician? YES NO phone # _____

Any family history of migraine headaches, seizures, genetic disorders, etc.?

List sicknesses (i.e. ear infections, colds, etc.) operations, and injuries. Indicate age when occurred and describe how severe. Please mention head injuries and any time when child was unconscious or had convulsions or was delirious or had a very high fever.

Does your child have a physical handicap? If so, describe.

Has your child been under any form of medication? If so, what medication, dates, supervising physician, and the reason.

Describe current eating and sleeping patterns.

Vision_____Does child wear contacts/glasses?_____

Hearing:_____Hearing Aid?_____Tubes?_____

Describe fine and gross motor skills, as well as any problems with awkwardness or clumsiness.

Describe vigor and/or activity level.

Education History

Name of current teacher (s) _____

Permission to consult with teachers? YES NO phone # or e-mail _____

List previous schools and dates attended

What are your child's grades like now and in the past?

Please describe specific areas of concern and areas you feel are academic strengths:

How much homework does your child have at night? Are there any difficulties or issues with starting, sticking with or finishing homework?

Has your child ever repeated a grade (including PreK and kindergarten)? If so, when? If so, what was the reason? Please note if your child attended a "young 5's" program.

Has your child ever been referred for testing?

Has your child ever received special education or learning support services at school? If so, describe the program and start date.

Previous test data from your child's school. Copies of previous test data from the school should be obtained and attached. (e.g, JATP, IEP, CRCT, ITBS, CoGAT, ERB, Stanford 9).

Provide relevant samples of your child's current work. If suspect that your child has a reading or writing problem, provide samples that demonstrates your concern. If your child has a portfolio of work at school, pick a few examples representative of different points in the year to show development.

Specialized Support Services

Please list any specialized support services your child has received and from whom.
Include copies of evaluations, IEPs, treatment plans, or progress reports.

Physical Therapy:
Dates of service: _____
Reason for referral _____
Name of specialist(s) _____
Permission to consult with specialist(s)? YES NO phone # or e-mail _____

Occupational Therapy:
Dates of Service: _____
Reason for referral _____
Name of specialist(s) _____
Permission to consult with specialist(s)? YES NO phone # or e-mail _____

Speech/Language Therapy:
Dates of Service: _____
Reason for referral _____
Name of specialist(s) _____
Permission to consult with specialist(s)? YES NO phone # or e-mail _____

Tutoring:
Dates of Service: _____
Reason for referral _____
Name of specialist(s) _____
Permission to consult with specialist(s)? YES NO phone # or e-mail _____

Counseling/Therapy:
Dates of Service: _____
Reason for referral _____
Name of specialist(s) _____
Permission to consult with specialist(s)? YES NO phone # or e-mail _____

Psychoeducational or Neuropsychological Evaluation
Dates of Service: _____
Reason for referral _____
Name of specialist(s) _____
Permission to consult with specialist(s)? YES NO phone # or e-mail _____

Other
Dates of Service: _____
Reason for referral _____
Name of specialist(s) _____
Permission to consult with specialist(s)? YES NO phone # or e-mail _____

Behavior and Adaptive Skills

Please check any behaviors that describe your child and add any comments you feel would be informative to our evaluation:

Behaviors **Comments**

_____Short attention span or poor concentration
_____Forgetful
_____Restless (overactive)
_____Impulsive
_____Aggressive
_____Difficulty following directions
_____Difficulty with authority
_____Lacks confidence in self
_____Temper Tantrums
_____Speech difficulties
_____Displays immature behavior
_____Daydreams excessively
_____Constantly seeks teacher attention
_____Withdrawn
_____Difficulty making or keeping friends
_____Poor eye-hand coordination
_____Slow in completing work
_____Right-left confusion
_____Limited vocabulary
_____Difficulty expressing emotions appropriately
_____Poor Eye contact
_____Accident Prone
_____Bites nails
_____Has tics/or twitches
_____Difficulty adjusting to/upset by changes to routine
_____Repetitive behaviors
_____ Strong interests or "obsessions"
_____ Difficulty with transitions

Describe any unusual or intense fears or shyness

Describe any unusual behaviors, rituals, habits, etc.

How would you describe your child's mood?

Has your child ever been diagnosed with a mood disorder such as anxiety or depression?

What is your child's usual disposition?

What do you find most difficult about raising your child?

What is the most effective form of discipline? Do caregivers agree on discipline?

How does your child usually respond to disciplinary correction?

Describe child's relationship with the following:

Peers (at home and at school)

Siblings

Mother

Father

Teacher

Significant others (e.g., nanny, au pair, girlfriend/boyfriend, relative)

Adults in general

What activities does your child enjoy? (Sports, hobbies, interests, etc.)

What are your child's strengths? What do you enjoy the most about your child?

Please provide any additional information that you think might be helpful.

3500 Piedmont Road
Suite 740
Atlanta, GA
30305