Sakura Center
FOR PSYCHOLOGICAL ASSESSMENT AND THERAPY

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DEMOGRAPHIC FORMS-CHILD EVALUATION

General Information

Today's Date: ___/___/_____ Child's Date of Birth: ___/___/_____ Child's Age: _____

Child's Full Name: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Phone: Home: _____Is it okay to leave a detailed message at this number? Yes ___ No ___

Cell: _____Is it okay to leave a detailed message at this number? Yes ___ No ___

E-Mail Address:

_____

Do I have your consent to email an appointment reminder prior to sessions? Yes ___ No ___

Do I have your consent to email digital copies of:

1) Records: Yes ___ No ___

2) Billing statements: Yes ___ No ___

Emergency contact or parent/guardian name:

_____

Phone #: _____ Email Address: _____

Please tell us a little more about your child:

Gender/Preferred pronouns: _____

Ethnicity: _____

Spiritual beliefs: _____

Disability (if any): _____

Sexual orientation: _____

School & Grade: _____

Handedness: _____

Who referred you to our service? Please provide contact information:

_____

Is this referral a result of or related to any legal or court proceedings? If so, please provide name of attorney.

_____

Please list the reason(s) for referral or primary concerns that led you to seek an evaluation at this time:

_____

_____

_____

Developmental/Medical History

Pregnancy and Birth

Pregnancy/Birth/Delivery Complications? Please Describe:

_____

_____

Medications used during pregnancy?

_____

Yes___ **No**___ Smoking? Frequency?_____

Yes___ **No**___ Drug Intake? Type?_____

AmountUsed/Frequency?_____

Yes___ **No**___ Alcohol? Amount/Frequency? _____

Length of pregnancy? (weeks): _____ Birth weight: _____ lbs. _____ oz.

Birth length: _____ APGAR scores: _____/_____

Type of delivery: spontaneous ____ induced ____ caesarean ____ with instruments ____ breech____

Any complications for mother or infant after birth? Please explain:

_____

_____

_____

Developmental Milestones

Yes___ **No**___ Enjoyed cuddling

Yes___ **No**___ More active than other babies

Yes___ **No**___ If child has other siblings, was development different in any way? Explain:

_____

_____

At what age did this child first do the following (indicate with year and month of age).

Turn over _____ Crawl _____ Walk Upstairs _____ Stand Alone _____

Walk Alone _____ First Words _____ First Phrases _____

Is child toilet Trained? **Yes**___ **No**___ If yes, Days? _____ Nights? _____

Did bed wetting or soiling occur after training? **Wetting** _____ **Soiling** _____ If yes, until what age?_____

Does your child have any speech difficulties

_____

Motor difficulties (e.g. clumsiness)?

_____

Does your child have difficulties with hygiene?

_____

Please list any other healthcare providers involved in your child's care (e.g., neurologists, pediatricians or other physicians, psychologists, social workers, therapists, special educators, occupational therapists, etc.)

_____

_____

_____

Medical History

Yes___ **No**___ Has your child's medical history been normal/unremarkable? If no, please explain:

_____

_____

_____

Yes___ **No**___ Has your child received any medical diagnoses? Please specify:

_____

_____

_____

Yes___ **No**___ Has your child had genetic testing?

Yes___ **No**___ Has your child had an MRI?

Yes___ **No**___ Has your child had an EEG?

Yes___ **No**___ Frequent ear infections?

Yes___ **No**___ Were ear tubes ever placed?

Yes___ **No**___ Hearing problems?

Yes___ **No**___ Vision problems?

Yes___ **No**___ Headaches?

Yes___ **No**___ Meningitis?

Yes___ **No**___ Seizures?

Yes___ **No**___ Asthma?

Yes___ **No**___ Slow/fast growth?

Yes___ **No**___ Head injury?

Yes___ **No**___ Allergies?

Yes___ **No**___ Hospitalizations? Describe below.

Yes___ **No**___ Physical/Sexual Abuse?

If yes to any of the above, please describe:

_____

_____

_____

Has your child ever been hospitalized, had surgeries, or major illnesses?

Age	*How long*	*Reason*
____	_____	_____
____	_____	_____

What medications does your child currently take? (Include over-the-counter supplements)

Name	*Dose*	*Frequency*	*Reason*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe your child's sleep routine:

Typical bed time: _____

Typical wake time: _____

Trouble falling asleep? **Yes___ No___**

Trouble staying asleep? **Yes___ No___**

Trouble waking up early? **Yes___ No___**

Any other sleep problems? Explain:

_____

Describe your child's diet:

_____

Describe your child's current level and type(s) of exercise:

_____

Mental Health History

Has your child had previous neuropsychological testing? **Yes___ No___**

If Yes, where? _____ When _____

Has your child had any additional testing (e.g., psychoeducational, speech/language?) **Yes___ No___**

If Yes, where? _____ When _____

**If you answered Yes to either of the above questions, please attach or otherwise provide report(s).*

Does your child currently receive psychotherapy services or counseling? **Yes___ No___**

In the past? **Yes___ No___** If Yes: Name of provider: _____ Dates: _____

Is your child seeing a psychiatrist for medication? **Yes___ No___**

Name of Psychiatrist: _____ Dates: _____

Medication the Psychiatrist Prescribed: _____

Is there any history of self-harm or suicidal thoughts, threats, or attempts? Please Explain:

_____

_____

List any previous or current mental health diagnoses:

_____

_____

Psychosocial Functioning

Describe the child's personality:

_____

_____

What are your child's non-academic strengths?

_____

_____

What are your child's non-academic weaknesses?

_____

_____

How does the child spend his/her free time?

_____

_____

In what community or extracurricular activities is your child involved?

_____

_____

Any concerns about child's social group/friends? Explain:

_____

_____

Any concerns about substance use? Explain:

_____

_____

Please place a mark next to behaviors that you believe your child exhibits to an *excessive or exaggerated degree* when compared to other children his or her age.

Sleeping and Eating

- ❑ Nightmares
- ❑ Trouble falling asleep
- ❑ Trouble staying asleep in the morning
- ❑ Excessive snoring during sleep
- ❑ Decreased need for sleep without getting tired
- ❑ Eating excessively or poor eating

Social Development

- ❑ Excessively shy or timid
- ❑ More interested in objects than people
- ❑ Difficulty making friends
- ❑ Difficulty maintaining friendships
- ❑Teased by other children

Social Development Cont.

- ❑ Bullies other Children
- ❑ Argues with adults
- ❑ Excessive daydreaming and fantasy life

Motor Skills

- ❑ Poor fine motor coordination
- ❑ Poor gross motor coordination
- ❑ Generally "clumsy"
- ❑ Poor letter formation
- ❑ Difficulty dressing

Other Problems

- ❑ Bladder control problems
- ❑ Poor bowel control (soils self)
- ❑ Any history of motor/vocal tics
- ❑ Overreacts to noises
- ❑ Overreacts to touch
- ❑ Problems with taste or smell

Behavior

- ❑ Stubborn
- ❑ Irritable, angry, or resentful
- ❑ Frequent tantrums
- ❑ Strikes out at others
- ❑ Throws or destroys things
- ❑ Lying
- ❑ Stealing
- ❑ Argues with adults
- ❑ Daredevil behavior
- ❑ Runs away

Behavior Cont.

- ❑ Needs a lot of supervision
- ❑ Doesn't empathize with others
- ❑ Overly trusting of others
- ❑ Doesn't appreciate humor
- ❑ Impulsive (does things without thinking)
- ❑ Poor sense of danger
- ❑ Skips school
- ❑ Seems depressed
- ❑ Cries frequently
- ❑ Excessively worried and anxious
- ❑ Overly preoccupied with details
- ❑ Overly attached to certain objects
- ❑ Not affected by negative consequences
- ❑ Drug Use
- ❑ Alcohol Use
- ❑ Sexual activity, behavior, or sexual talk
- ❑ Not sought out for friendship by peers
- ❑ Difficulty seeing another person's point of view

Family History

Parents are (choose one): **Married _____ Separated _____ Divorced _____ Living Together _____**

If separated or divorced; how old was the child when the separation occurred_____

Child lives with (choose one): **Both parents _____ Mother _____ Father _____ Other _____**

Who has legal custody?

_____

Who else lives in the home?

_____

Biological Mother

Current age: _____

Name: _____

Occupation: _____

Highest grade completed: _____

Biological Father

Current age: _____

Name: _____

Occupation: _____

Highest grade completed: _____

Siblings:

Name	Age	Medical, social, academic, mental health concerns

Have any of the following conditions occurred among the child's blood relatives (parents, aunts, uncles, grandparents)? Check those that apply:

❑ Allergies
❑ Amnesia
❑ Asthma
❑ ADHD
❑ Bleeding tendency
❑ Depression
❑ Cancer
❑ Suicide
❑ Learning problems
❑ Deafness
❑ Diabetes
❑ Glandular problems
❑ Heart diseases
❑ High blood pressure
❑ Kidney disease
❑ Alcohol/drug problem
❑ Anxiety
❑ Autism/Asperger's
❑ Intellectual disability/ cognitive delay
❑ Seizures
❑ Cerebral Palsy
❑ Migraines
❑ Muscular Dystrophy
❑ Schizophrenia
❑ Dementia/cognitive decline
❑ Other (specify): _____

Does anyone in the family have similar difficulties to the child? If yes, please describe:

If child is adopted...

Adoption source:

Reason and circumstances:

Age when child first in home: _____ Date of legal adoption:_____

What has the child been told regarding their adoption_____

Academic History

Child's current grade: _____

School Name: _____ **Public** _____ **Private** _____

School District: _____

What preschool experience did your child have?

_____

Were there any problems detected in your child's kindergarten screening? **Yes___ No___**

If yes, please explain:

_____

_____

Does your child have an IEP or 504 Plan, or another modified learning program? **Yes___ No___**

Is your child in a regular classroom? **Yes___ No___**

If no, please explain:

_____

Please check any services child currently receives through an IEP or 504 Plan (if applicable):

____ Speech therapy ____ Occupational therapy ____ Physical therapy

____ Adaptive PE ____ Tutoring ____ Pull-out services (math, reading, writing)

What are your child's typical grades?

_____

How does your child typically perform on standardized tests/district assessments? _____

What are your child's strongest and weakest points, academically?

_____

_____

Are you satisfied with your child's educational program? **Yes___ No___**

If no, please explain:

_____

_____

Legal History

Has the child been involved with the court currently or in the past? **Yes___ No___**

Date(s):_____

Describe:_____

_____

Current Probation? **Yes___ No___** Probation Officer: _____ Phone #: _____

Is there any other pertinent information to your child's evaluation that you would like to include here? Do you have any questions you would like to ask your child's clinician at your intake appointment? (This section can be left blank):

_____

_____

_____

_____

_____

_____

_____