Child's Name: ______________________________

Date of Birth: ______________ Today's Date: ______________

Individual Completing Packet: ______________________________

Relationship to Child: ______________________________

Complete Home Address: ______________________________

Home Phone: ______________ Parent Cell: ______________

Work Phone: ______________ Parent Cell: ______________

Parent E-Mail: ______________________________

Parent E-Mail: ______________________________

Parent Relationship Status (circle): Married, Separated, Divorced, Never Married, Widowed

Siblings? Please list name(s) and age(s) below:

____

____

____

Child's current school, grade and teacher:

____

____

Is your Child Receiving Special Education Services? If so, for what Diagnoses?:

____

____

Briefly state the reason for assessment; what question(s) are you hoping to answer?:

____

____

____

____

On the next several pages there are a variety of questions. Please answer each item as completely and honestly as possible. These responses lay a foundation through which I can begin to understand the environment which your child operates in and the context that surrounds them each day.

Family Life and History

Who does your child live with?: ____________________

Where was your child born?: ____________________

What is the ethnic makeup of the family members?

Mother: ____________________ Father: ____________________

Stepparents: ____________________

Siblings: ____________________

Languages spoken in the home (please circle the primary language if there is more than one):

____

Does your child practice a religion? Which?: ____________________

If so, how important is this practice to the family?: ____________________

____

To the child?: ____________________

____

Are there family/cultural traditions that are practiced? Please describe: ____________________

____

____

____

What are your child's hobbies or interests?: ____________________

____

____

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Favorite foods?: ______________________________

____

Major family events? For example, births, deaths, moves,changing schools, etc. Please provide date and details: ______________________________

____

____

____

How does your child get along with their sibling(s)?: ______________________________

____

____

Please describe the quality of the parental relationship(s) –both with each other and with your child:______________________________

____

____

____

____

Parent(s) occupation(s) and hobbies: ______________________________

____

____

____

Has the child been in out-of-home care? If so, at what ages and for how long: ______________________________

____

____

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Academics

For each grade level, please list where the child attended:

Preschool: ____________________

K: ____________________

1st: ____________________

2nd: ____________________

3rd: ____________________

4th: ____________________

5th: ____________________

6th: ____________________

7th: ____________________

8th: ____________________

9th: ____________________

10th: ____________________

11th: ____________________

12th: ____________________

Please list any awards (e.g., honor roll, Principal's list, citizenship, etc.) and year(s) received:

____

____

Does your child like school? Please explain: ____________________

____

____

____

Dr. Sorci may request copies of report cards and IEP documents if pertinent.

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Developmental History

Pregnancy and Delivery –

How was Mom's health during pregnancy?: ____

____

Alcohol or substance use during pregnancy?: ____

____

Was delivery complicated? Full-term? C-section? Please describe details of the birth: __________

____

____

Developmental Milestones –

At what age did your child –

Sit on their own: _________ Crawl: _________ Walk: _________

Speak first words: _________ Speak in 2 – 3 word sentences: _________

Toilet train, daytime: _________ Nighttime: _________

Comments or other notes about developmental milestones: _____________________________

____

____

Sleep Habits –

What is your child's bedtime routine or ritual?: ____

____

Nightmares? Night terrors? Sleep walking or talking?: ______________________________________

____

____

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Medical History

Please describe your child's health, in general: ____

____

____

____

When was your child's last physical?: ____

Any hearing, vision, or dental problems? If so, please describe: __________________________

____

____

Any chronic health problems not described above (e.g., asthma, diabetes)?: ________________

____

____

Any head trauma, concussion, loss of consciousness? If so, when and what were the circumstances?:

____

____

____

Please list any medications your child is taking, ***both prescription and over-the-counter***, dosage and reason for taking:

Medication	Dosage and frequency	Reason

Mental Health Background

Please list dates and the reason for admission of any inpatient psychiatric treatment your child has received: ___

___

___

Please list, chronologically, all therapy or counseling your child has received:

Dates of treatment	Professional	Reason for treatment

Has your child ever harmed him or herself? Suicide attempt(s)? Cutting or self-injurious behavior? Deliberate or non-deliberate harm? Please describe: ___

___

___

___

Substance use or experimentation – including cigarettes, marijuana, and nitrous: ___

___

___

___

Family Mental Health Background –

Please list any relatives (parents, siblings, grandparents, aunts, uncles, etc.) with mental health diagnoses (depression, anxiety, eating disorder, bipolar, etc.):

Relative	Diagnosis

Please take a moment and share any information that you feel was not included on these pages that is important for your child's assessment:

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