Psycho-Educational Evaluations for Kids, LLC
(813) 922-8249
605 W. Bloomingdale Ave
Brandon, FL 33511

Today's Date:________________

Name of Person Completing this Form: ___________________________ Relationship to Child: ______________

Child's Name: __________________ Date of Birth: _________________ Age: _____________

School: ____ Grade: __________________

Home Address: ____

Phone Number: __________________ Email Address:____

Best method of contact: __________________

Please list ANY current concerns you are having about your child?

1.____________________________________4. ___________________________________

2.____________________________________5. ___________________________________

3.____________________________________6. ___________________________________

Has your child ever had any previous educational and/or psychological evaluations?

Please indicate your child's strengths/unique talents and interests:

1._____________________________________4. ____

2._____________________________________5. ____

3._____________________________________6. ____

What would you hope to get out of this evaluation for your child?

EARLY HISTORY:

Length of Pregnancy? _______________ Birth Weight? ___ lbs. ____ ozs.

Any problems/complications during pregnancy?

Any medications and/or medical treatments during pregnancy?

Any problems during labor/birth?

MEDICAL HISTORY

Please list all heath conditions (present and past) – please provide dates:

1.________________________________2. _______________________________

3.________________________________4. _______________________________

Has your child ever been hospitalized? ____ Yes ____No

If so, when/what condition?

Please list current medication(s), dosages, name of prescribing physician/ psychiatrist and when first prescribed:

Please list all other significant illnesses:

EARLY DEVELOPMENT (Please indicated the approximate time period - age)

Sat up without help ____________ Walked alone ________________

Crawled______________________ Spoke first words (mama, dada, etc.) ____________

Spoke 2-3 word sentences ______________ Used fingers to feed self _____________________

Fully toilet trained ____________________ Able to dress self____________

Any developmental or other concerns during your child's 1st year of life?

Has this child endured any extremely stressful experiences?

FAMILY HISTORY

Father's Age: _________ Occupation: ___________________

Mother's Age: _______ Occupation:____________________

Brother(s) Age: ____

Sister(s) Age: ____

Please check any that apply:

___ Was adopted ___ Is a foster child

Parents are: ___ Together ___ Separated ___ Divorced

What is the primary language spoken at home?_________________________

Indicate others languages that are sometimes used?______________________

Has anyone in the family ever had any previous diagnoses or treatment as a child or adult for learning disabilities, autism, attention deficit disorder, anxiety, depression, behavioral problems. Please describe:

EDUCATIONAL HISTORY:

Was this student ever retained in a grade?

☐ Yes Grade: ☐ No

Is your child currently receiving Multi-Tiered System of Supports services? Circle one: Yes No Unsure

Has your child ever experienced any significant difficulties over a period of more than 6 months in the following areas? Check all that apply:

☐ Attention ☐ Organization ☐ Forgetfulness ☐ Homework Completion ☐ Making/keeping friends

☐ Test taking ☐ Anxiety ☐ Depression ☐ Hyperactivity ☐ Distractibility ☐ Aggression ☐ Compliance

☐ School Refusal ☐ Confidence ☐ Social Skills ☐ Emotional Meltdowns

Has your child had any previous or current suicidal or self-injurious behavior or verbalizations? ___ Yes ___ No

Has your child received any special educational services? Did he/she ever have an IEP, Section 504 plan, accommodations (formal or informal), or specialized tutoring?

If so, please describe:

Thank you for your time and attention!