Education Consultation: Information Form

Name: _____ Sex: _____ Birthdate: _____ Provider: _____

Evaluation date: _____ Form filled out by: _____

Referred by: _____

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Briefly describe the events that led to this appointment.

_____

_____

_____

_____

_____

_____

_____

What concerns you most about your child?

_____

_____

_____

_____

What are your goals for the consultation?

_____

_____

_____

_____

Treatment History

If there are any completed Psychological or Medical Testing, complete the chart below and bring any findings you have to the appointment.

Date	Provider	Diagnoses or Findings

Are you currently seeing other professionals about these problems? If yes, list these contacts and approximate dates of evaluation and treatment (include hospitalization).

Date	Provider or Site of Evaluation / Treatment

Education Consultation: Information Form

Name: _____ Date: _____ Provider: _____

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Please list past and current medications and approximate doses and dates of treatment.

Date	Medication	Dose

What do you see as your child's strengths and weaknesses?

_____

_____

_____

_____

School History

What is your child's current grade, special program, school?

_____

What other schools and/or programs has she/he attended?

_____

_____

_____

If there are any completed Educational Assessments, complete the chart below and bring any findings you have to the appointment.

Date	Teacher / School	Outcome

Education Consultation: Information Form

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If you have had any of the following assessments, bring the findings to the appointment.

- ☐ Speech and Language
- ☐ OT Assessment
- ☐ PT Assessment

If you have had any of the following services, bring any associated materials to the appointment.

- ☐ 504 Plan
- ☐ Assistant / paraprofessional support
- ☐ Special Education (IEP)
- ☐ Behavior Intervention Plan

Please bring any pertinent work samples or notes / information from school to the appointment

What concerns do you have the school program?

_____

_____

_____

_____

_____

How is school perceived? What are your feelings about it?

_____

_____

_____

_____

What are your hopes for educational attainment and vocational future?

_____

_____

_____

_____

Social History

List the names, ages, and occupations/grades of family members in the current household.

_____

_____

_____

_____

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Patient: _____ Date: _____ Provider: _____

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List immediate relatives (biological or related by marriage, parents or siblings) or other primary caretakers (sitters, day care). Has there been any significant history of problems?

Are there any particular stresses or recent changes in the family such as job changes, financial problems, school changes, health problems, marriage or divorce, violence, or substance abuse?

How is behavior managed in the home? What methods work or haven't worked? Do caregivers / parents agree on discipline? Is there allowance? Are there chores?

How well I does the student get along

with siblings? _____

with peers? _____

with parents? _____

by himself/herself? _____

What are family activities or mealtimes like? Are there any other activities or hobbies? Favorite TV or movies?

Education Consultation: Information Form

Name _____ Date: _____ Provider: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

- ☐ careless / poor attention to details
- ☐ difficulty sustaining attention
- ☐ doesn't listen
- ☐ doesn't follow through with requests
- ☐ difficulty organizing
- ☐ avoids effortful tasks
- ☐ loses necessary things
- ☐ easily distracted
- ☐ forgetful in daily activities
- ☐ fidgets
- ☐ leaves seat
- ☐ runs about / subjectively restless
- ☐ difficulty playing quietly
- ☐ "On the go"/ "motor driven"
- ☐ excessive talk
- ☐ blurts out answers
- ☐ difficulty waiting turn
- ☐ interrupts/intrudes

Comments:

_____

_____

_____

_____

_____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

- ☐ stealing in or out of the home
- ☐ lying
- ☐ truancy / runaway
- ☐ violence in the family
- ☐ violence at school
- ☐ violence in the cummunity
- ☐ fire setting
- ☐ cruelty to animals
- ☐ legal involvement
- ☐ inappropriate sexual interests
- ☐ lack of conscience
- ☐ threats of violence
- ☐ exceptional negativity to rules
- ☐ involvement with juvenile services

Comments:

_____

_____

_____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

- ☐ alcohol use
- ☐ marijuana use
- ☐ cigarette use
- ☐ other substance abuse

Comments:

_____

_____

_____

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Education Consultation: Information Form

Name: _____ Date: _____ Provider: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

- ☐ expresses depression
- ☐ irritable, giddy, or elated
- ☐ hypersexuality
- ☐ loss of inhibition
- ☐ mood swings
- ☐ mood changes without reason
- ☐ lack of interest in friends
- ☐ lack of interests in normal activities
- ☐ poor sleep or excessive sleep
- ☐ poor eating or excessive eating
- ☐ any concerns about weight changes or dieting
- ☐ bingeing with or without purging
- ☐ suicidal talk
- ☐ acts of self harm or mutilation

Comments:

_____

_____

_____

_____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

- ☐ school refusal or excessive absences
- ☐ anxiety at bedtime
- ☐ refusal to sleep alone
- ☐ fears of harm to family
- ☐ medical complaints like headaches
- ☐ phobias (heights, spiders, etc)
- ☐ sudden feelings of panic
- ☐ refuses to speak in public
- ☐ refuses to go out in public
- ☐ history of trauma (abuse or accidental
- ☐ nail biting, skin picking, thumb sucking, etc.
- ☐ excessive hand washing or other repetitive acts
- ☐ over concern with germs or illnesses
- ☐ overly perfectionistic

Comments:

_____

_____

_____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

- ☐ odd thinking or ideas
- ☐ paranoid thinking
- ☐ difficulty discerning real from fantasy
- ☐ periods of odd sensations or memory loss
- ☐ hearing voices
- ☐ seeing things that are not there

Comments:

_____

_____

_____

_____

_____

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Education Consultation: Information Form

Name: _____ Date: _____ Provider: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

- ☐ tics or twitches of the mouth, eyes, arms, etc
- ☐ head banging or rocking
- ☐ repetitive acts causing self injury (biting, scratching, etc
- ☐ repetitive movements such as jumping or arm/hand flapping
- ☐ lack of affection (doesn't seek out or provide comfort
- ☐ little need for reassurance in a strange situation, or little stranger anxiety
- ☐ poor peer relations / no real friends
- ☐ problems understanding feelings of others during interactions
- ☐ distress over changes in routine
- ☐ unusual toy or play interests (collections, string, line up or take apart toys)
- ☐ restricted conversational interests (dinosaurs or specific topics to exclusion of other topic
- ☐ hoarding food or other objects

Comments:

PLEASE COMMENT BELOW IF YOU HAVE OTHER CONCERNS NOT MENTIONED IN THE PREVIOUS PAGES:

Comments:

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