

The Foundation for the School for Young Children
Robert J. Strudler Diagnostic and Remediation Center
3808 Garrott, Houston, Texas 77006 Phone: (713) 520-8002 Fax: (713) 520-1109

Child's Name: _____ **DOB:** _____ **Grade:** _____

***Reason for Referral:**

Please state the *reason(s) for your child's referral*: _____

Referral requested by(*please check all that apply*): ☐ Parent ☐ Teacher/School ☐ Tutor ☐ Other _____

Check area(s) of difficulty:

_____ Reading	_____ Social Studies	_____ Study Skills
_____ Math	_____ Oral Language	_____ Organization
_____ English/Creative Writing	_____ Foreign Language	_____ Memory
_____ Science	_____ Handwriting	_____ Attention/Focus

Perception of your child's strengths and weaknesses:

Strengths: _____

Weaknesses: _____

What are your child's **special interests, skills, or hobbies**? _____

Is this an **initial evaluation** or a ***re-evaluation**? ☐ Initial ☐ Re-evaluation

*If this is a re-evaluation, please put the **date of last evaluation** and the **educational**
diagnostician/psychologist/clinician who completed the assessment: _____

****PLEASE ATTACH RESULTS OF ANY PREVIOUS TESTING****

***Child's History:**

The following questions are asked so that I can best understand your child. Please fill out this questionnaire before your child is evaluated. Please read the questions carefully and answer them as fully as possible. Use the back of the sheet if necessary. If there any questions you don't understand, they can filled out with my help when I review the history with you. Please star (*) such questions.

General Information

Child's Legal Name: _____

Home Address: _____

City: _____ Zip Code: _____

Home Phone: _____ Cell Phone (parent's # if child is under 18): _____

Email (parent's email if child is under 18): _____

Primary language(s) spoken in the home: _____

If bilingual, approximate age at which child began speaking English _____.

Family History

Child is living with: ☐ Both Parents ☐ Mother ☐ Father ☐ Mother and Stepfather ☐ Father and Stepmother
☐ Legal Guardian ☐ Other (please specify) _____

Is your child **adopted**? ☐ Yes ☐ No Child's age at adoption: _____

Status of parents' marriage: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

If divorced: *How long? _____ *Child's age at divorce: _____; *Describe Custody Arrangements (sole, joint) _____; *Which parent is requesting this appointment for child? _____

Birth Mother***Birth Father***

Name: _____ Name: _____

Age: _____ Age: _____

Highest academic grade completed: _____ Highest academic grade completed: _____

Occupation/Field: _____ Occupation/Field: _____

and/or

Adoptive Mother/Stepmother/Other***Adoptive Father/Stepfather/Other***

Name: _____

Name: _____

Age: _____

Age: _____

Highest academic grade completed: _____

Highest academic grade completed: _____

Occupation/Field: _____

Occupation/Field: _____

Other Children*(Including step-siblings and half-siblings)*

Name	Sex	Age	Grade	Currently living in the home?	Any school/health problems(<i>please explain</i>)
	M F			Y N	
	M F			Y N	
	M F			Y N	
	M F			Y N	
	M F			Y N	

Biological Extended Family

Do any **extended family members** (*maternal/paternal grandparents, uncles, aunts, cousins*) suffer from learning problems, developmental disabilities, and/or inattentiveness/hyperactivity?

Mother (mother's side)

Father (father's side)

Please provide any other information **about your extended family** that might help me understand your child's needs (*medical, developmental, educational*).

Birth and Developmental History:*Pregnancy**

Length in months: _____

Any illnesses or complications while pregnant? ☐ Yes ☐ No If **yes**, please explain: _____

Labor and Delivery

Was the birth of your child "normal"? ☐ Yes ☐ No If **no**, please explain: _____

Perinatal History

Birth weight: _____ Length: _____ APGAR scores (***if known***): _____

Did mother **or** baby stay in Special or Intensive Care? ☐ Yes ☐ No Reason for stay: _____

Infancy and Early Childhood

Please rate your child on the following behaviors: Circle **1** if the behavior on the left was present the majority of the time. Circle **5** if the behavior on the right was present the majority of the time. Stages in between are represented by 2, 3, and 4. If there are two behaviors listed (e.g., accident prone and daredevil), please check the one that was present.

quiet and content	1	2	3	4	5	colicky and irritable
very easy to feed	1	2	3	4	5	daily feeding problems
slept well	1	2	3	4	5	frequent sleeping problems
usually relaxed	1	2	3	4	5	often restless
underactive	1	2	3	4	5	overactive
cuddly, easy to hold	1	2	3	4	5	did not enjoy cuddling
easily calmed down	1	2	3	4	5	tantrums
cautious and careful	1	2	3	4	5	<input type="checkbox"/> accident prone <input type="checkbox"/> daredevil
coordinated	1	2	3	4	5	uncoordinated
enjoyed eye contact	1	2	3	4	5	avoided eye contact
liked people	1	2	3	4	5	disliked contact with people

Other problems or comments regarding infancy **or** early childhood development (***if any***): _____

Ages at Milestones (if known) – Can also answer “within normal limits” or WNL

Gross Motor Skills	Age	Fine Motor Skills	Age
Crawled	_____	Fed self with spoon	_____
Walked Alone	_____	Scribbled	_____
Ran Well	_____	Tied Shoe	_____
Language Skills	Age		
Used Single Words	_____		
Used Sentences (2+ words)	_____		

***Medical History:**

Has your child been taken to the **emergency room** with a serious emergency, hospitalized, or had outpatient surgery **since birth**? ☐ Yes ☐ No If yes, please describe condition/injury, treatment/surgery, when, how long: _____

If your child had a head injury **did he/she lose consciousness**? ☐ Yes ☐ No If yes, how long? _____

Do you see your child as being: ☐ hyperactive? ☐ inattentive? ☐ a behavior problem? ☐ n/a

Does your child seem to be **able to control his/her behavior and attention**? ☐ Yes ☐ No

If no, please explain: _____

Has your child **ever been diagnosed** by a psychologist, physician, or other professional as having **ADHD** (*Attention-Deficit/Hyperactivity Disorder*)? ☐ Yes ☐ No If yes, when and by whom? _____

What **medication(s)** has your child received for ADHD (*include dosage, times, and length of time on medication*)? _____

****Please list all medications currently being taken by your child, including nonprescription medications (*with dosage and frequency*):** _____

Date of last hearing test: _____ Were the results normal? ☐ Yes ☐ No

If no, please explain: _____

Date of last vision test: _____ Were the results normal? ☐ Yes ☐ No

Does your child wear: ☐ Glasses? ☐ Contacts? **Why?** (*i.e., nearsighted*) _____

Please tell me about your child's **nightly sleep habits**: ☐ 4-6 hours ☐ 6-8 hours ☐ 8-10 hours ☐ more than 10 hours.

Does your child suffer from **allergies**? ☐ Yes ☐ No If yes, please explain: _____

Overall, your child's current health is: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Present Personality and Behavior

Please *circle all traits* that apply to your child the **majority of the time**:

sad happy leader follower moody friendly quiet overactive independent
 dependent sensitive affectionate fearful cooperative tantrums lethargic confident
 too responsible hard to discipline even-tempered prefers to be alone aggressive anxious relaxed

***Educational History:**

Current grade and school: _____

List ***previous*** school(s) ***and*** grades attended: _____

Briefly describe your child's performance and any concerns(***if any***) in each grade:

Kindergarten: _____

1st grade: _____

2nd grade: _____

3rd grade: _____

4th grade: _____

5th grade: _____

Middle School: _____

High School: _____

Has your child **repeated a grade**? ☐ Yes ☐ No If **yes**, list grade repeated and circumstances?

Has your child been previously diagnosed with a:

☐ Learning Disability (*please specify*): _____

☐ Speech/Language Disorder (*please specify*): _____

☐ Developmental Delay (*please specify*): _____

Has your child been **placed in special services** (*i.e., special education programs, 504 services, or RTI*) currently ***or*** in the past? ☐ Yes ☐ No If **yes**, please describe:

Category: _____

Does your child **currently** receive tutoring? ☐ Yes ☐ No

Has your child **received tutoring in the past**? ☐ Yes ☐ No

If **yes**, what area(s)? _____ **Frequency?** _____

Please add any **additional comments** you think might be helpful to me: _____

Signature: _____ / _____
Individual completing the form *Relationship to the child*

Date: _____