# PERSONAL INFORMATION

## Personal Information

Student/Client_____ Date of Birth_____

Address_____ Home Phone_____

_____ Lives With_____

If not living with both natural parents, please describe the student's current living arrangements

_____ Is the client adopted? □Yes □ No

Billing Address_____

Mother's Name_____ Father's Name_____

Mother's Occupation_____ Father's Occupation_____

Email Address_____ Email Address_____

Work Phone_____ Work Phone_____

Cell Phone_____ Cell Phone_____

Additional Emergency Contact_____ Phone_____

Referred by _____ Reason_____

## School Information

**Please list schools attended and indicate grade or age for each:**

Present School _____ Grade_____ Teacher's Name_____

Preschool _____ Grade or Age_____

Elementary_____ Grade or Age_____

Junior High/Middle School _____ Grade or Age_____

High School_____ Grade or Age_____

Has the client repeated a grade? □Yes □No If so, explain_____

Has client had a learning assessment before? □Yes □No Date_____

What were findings_____

Current Interventions_____

Previous Interventions_____

Goals and expectations for

Client/Student_____

**School Information Part Two:**

*Please circle what best describes your child's school experience*

| | Very Positive (5) | Positive (4) | Satisfactory (3) | Negative (2) | Very Negative (1) |
|---|---|---|---|---|---|
| Pre-school/Daycare | 5 | 4 | 3 | 2 | 1 |
| K-Grade 3 | 5 | 4 | 3 | 2 | 1 |
| Grades 4-6 | 5 | 4 | 3 | 2 | 1 |
| Grades 7-8 | 5 | 4 | 3 | 2 | 1 |
| Grades 9-12 | 5 | 4 | 3 | 2 | 1 |
| College | 5 | 4 | 3 | 2 | 1 |

Does student/client exhibit behaviors at home or school that concern you? ☐Yes ☐No

If yes, please describe the behaviors that concern you_____

What methods are used for discipline?_____

Are these methods effective? ☐Yes ☐No

What present behavior is most difficult for you to cope with?_____

Does student/client have regular playmates or friends? ☐Yes ☐No

## Medical History

Client's Physician_____ Phone_____

**Please list any agencies, psychologists, speech pathologists, tutors, educational therapists and other professionals who have evaluated and/or provided treatment**

| Name | Profession | Date(s) of Treatment |
|---|---|---|
| | | |
| | | |
| | | |

| Medications | Allergies | Other Medical Information |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Ear infection or hearing problems (give frequency and severity)_____

How many before the age of five years:_____

Has hearing been checked by physician: ☐Yes ☐No If yes, when:_____ By whom:_____

Eye or vision problems: ☐Yes ☐No Glasses: ☐Yes ☐No Anemia_____

Vomiting spells: ☐Yes ☐No Frequent Diarrhea: ☐Yes ☐No Seizures: ☐Yes ☐No

Frequent Colds: ☐Yes ☐No Asthma: ☐Yes ☐No Meningitis: ☐Yes ☐No

Kidney or urine problems: ☐Yes ☐No Head Injury: ☐Yes ☐No

## Family Medical History

**While pregnant did the client's mother have any of the following:**

_____German measles _____Vaginal infection or bleeding _____Diabetes
_____Anemia (low iron) _____Have a high fever _____Smoke cigarettes
_____Kidney problems _____Use alcohol _____Use drugs
_____High blood pressure

Any severe emotional problems_____

Any serious illness / accidents during pregnancy_____

Medications taken during pregnancy_____

Comments_____

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## Birth History

Was client born early: □Yes □No Late: □Yes □No On time: □Yes □No

Was client born by C-section: □Yes □No If yes, please give reason_____

Duration of labor_____ Birth weight_____

Injuries, bruises, deformities of head_____

Breathing difficulties: □Yes □No

Feeding difficulties: □Yes □No

In incubator or ICU: □Yes □No If yes, how long:_____ Jaundice_____

Anoxia: □Yes □No

Other unusual conditions_____

_____

**Please indicate which relatives, if any, who have had specific learning disabilities:**

*_____ *_____

*_____ *_____

**List Brothers and Sisters in Order of Birth**

| Name | Sex | Birthdates | Describe client's relationship with each |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Comments or pertinent information**_____

_____

_____

_____

_____ _____

**Signature of person filling out history** **Date**