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

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_____

Previous assessments:

___Psychoeducational, ___Visual. ____Audiological, ___Neuropsych, ___Speech/Language, ___Other

What were findings_____

Current Interventions_____

Previous Interventions_____

IEP _____504 Plan_____Other support_____

School Information Part Two: ***Circle what best describes school experiences***

	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

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 Explain:_____

Client 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:_____ Tubes/surgeries: _____

Has hearing been checked by physician: □Yes □No If yes, when:_____By whom:_____

Eye or vision problems: □Yes □No Glasses: □Yes □No Last check-up: _____

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 Other:_____ 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_____

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_____

_____

_____

_____

Specific reasons you are contacting Banyan Tree at this time. Be specific about goals or areas of need to be addressed._____

_____

_____

_____

_____ _____

Signature of person filling out history **Date**