

PARENT INFORMATION

The following information is being provided by \_\_\_\_\_ on \_\_\_\_\_ as part of the Multidisciplinary Evaluation of \_\_\_\_\_.

**1. Demographic Data:**

Child's Name: \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**Mother/Guardian/Step Mother (circle)**

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Home Address: \_\_\_\_\_

Education: \_\_\_\_\_

Learning/Behavior issues in school: \_\_\_\_\_

Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**Father/Guardian/Step Father (circle)**

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Home Address: \_\_\_\_\_

Education: \_\_\_\_\_

Learning/Behavior issues in school: \_\_\_\_\_

Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Brothers/Sisters Names	Birthdate	School/Grade	Problem (learning, medical, speech, behavior, etc.) and supports provided.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other people living in the home: \_\_\_\_\_

Please describe any additional family history of significant medical, emotional, or learning issues (e.g. I.D, ADD, depression, anxiety, or other medical, emotional or learning issues) among other family members (grandparents, aunts, uncles, cousins, etc).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Medical/Developmental History

Did mother have prenatal care? \_\_\_\_\_ Was mother under significant stress during pregnancy? \_\_\_\_\_

Describe any difficulties/complications during pregnancy \_\_\_\_\_

Type of Delivery: Normal \_\_\_\_\_ Forceps \_\_\_\_\_ Cesarean: \_\_\_\_\_ Reason for Cesarean \_\_\_\_\_

Describe any difficulties/complications during delivery \_\_\_\_\_

Full term: \_\_\_\_\_ Birthweight: \_\_\_\_\_ Premature: \_\_\_\_\_ Length of Pregnancy: \_\_\_\_\_

Was the child healthy at birth \_\_\_\_\_ . If not, please describe any difficulties \_\_\_\_\_

At what age did your child:

Walk independently: \_\_\_\_\_

Speak first words: \_\_\_\_\_

Speak in complete sentences: \_\_\_\_\_

Complete toilet training: \_\_\_\_\_

Please describe any other developmental concerns: \_\_\_\_\_

Please describe any medical issues (medical diagnoses, allergies, asthma, history of ear infections, serious illnesses, high fevers, seizures, serious accidents, surgeries, hospitalizations, mental health concerns, etc) including dates, treatments, and response to treatments. If applicable, please indicate current medications and dosages.

3. Educational History of Child

School (including preschool)	Grade	Date	Describe any concerns or special services
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Current Functioning at Home

Chores and responsibilities: \_\_\_\_\_  
\_\_\_\_\_

Academic/Reading behaviors at home and behavior at homework time: \_\_\_\_\_  
\_\_\_\_\_

Describe discipline methods: \_\_\_\_\_  
\_\_\_\_\_

Behaviors needing discipline and their frequency: \_\_\_\_\_  
\_\_\_\_\_

Child's response to discipline/effectiveness: \_\_\_\_\_  
\_\_\_\_\_

Child's interests/hobbies/special talents/ lessons/clubs/sports teams: \_\_\_\_\_  
\_\_\_\_\_

5. Social Skills/Relationships

Interactions with mother: \_\_\_\_\_  
\_\_\_\_\_

Interactions with father: \_\_\_\_\_  
\_\_\_\_\_

Interactions with siblings: \_\_\_\_\_  
\_\_\_\_\_

Interactions with peers: \_\_\_\_\_  
\_\_\_\_\_

6. Parent Concerns

Describe your current concerns and the child's weaknesses: \_\_\_\_\_  
\_\_\_\_\_

Describe your child's strengths: \_\_\_\_\_  
\_\_\_\_\_

Describe strategies/supports that benefit your child: \_\_\_\_\_  
\_\_\_\_\_

Provide any additional information you feel is relevant to understanding your child's educational needs: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If applicable, please indicate any involvement of the court system, probation officers, mental health organizations, or other community based resources and support systems (including names and contact numbers of service providers):

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**7. Social/Emotional Behaviors:**

Please respond to the following:

	Often	Sometimes	Seldom	Never
1. Happy, outgoing				
2. Shy, withdrawn, timid				
3. Mild mannered				
4. Aggressive				
5. Temper tantrums				
6. Fearful (dark, alone, animals, please specify)				
7. Seeks help for things he/she can do alone				
8. Affectionate				
9. Plays well with others				
10. Relates well socially to others				
11. Readily manageable				
12. Irritable				
13. Sensitive				
14. Nervous				
15. Stubborn				
16. Clumsy				
17. Easily frustrated				
18. Destructive (intentional)				
19. Daydreams				
20. Has difficulty changing from one thing to another				
21. Trusting and gullible				
22. Gets along well with brothers and/or sisters				
23. Follows directions				
24. Movements appear smooth				
25. During meals is:				
Up and down at the table				
Fiddles/plays with food				
Chews adequately				
Has good appetite				
Is a picky eater				
26. Sleep:				
Has difficulty settling down				
Gets enough sleep				
Restless during sleep				
Has frequent nightmares				

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_