Initial Evaluation — Parent History Form

Kristen Beckley, LLC Kristen Beckley, M.A., C.A.G.S., NCSP

P.O. Box 11, Durham, NH 03824 • kristen@kristenbeckley.com • 978-255-3044

Please complete this form before your child's evaluation. Fields marked with an asterisk (*) are required. You may tab between fields and check the boxes that apply. All information is kept confidential.

1 Child Information

Child's Full Name *

Date of Birth *

Age

Gender

Current Grade *

Current School

School District

2 Parent / Guardian Information

Parent / Guardian 1

Name *

Relationship to Child *

Phone *

Email Address *

Street Address

City

State

Zip Code

Parent / Guardian 2 (optional)

Name

Relationship to Child

Phone

Email Address

3 Family Information

Child Lives With

- [ ] Both parents
- [ ] Mother only
- [ ] Father only
- [ ] Mother & stepfather
- [ ] Father & stepmother
- [ ] Grandparent(s)
- [ ] Legal guardian
- [ ] Other

If other, please specify

Parents' Marital Status

○ Married ○ Separated ○ Divorced ○ Widowed ○ Never married

Is the child adopted?

○ Yes ○ No

Age at adoption (if applicable)

Siblings (name, age, grade — list up to 8)

Relevant Family History

4 Reason for Referral

Primary Concerns *

Areas of Concern (check all that apply)

- [ ] Reading / Decoding
- [ ] Reading Comprehension
- [ ] Written Expression
- [ ] Math Calculation
- [ ] Math Reasoning
- [ ] Attention / Focus
- [ ] Hyperactivity / Impulsivity
- [ ] Executive Functioning (planning, organization, time management, working memory, task initiation, flexibility)

- [ ] Speech / Language
- [ ] Social Skills
- [ ] Anxiety
- [ ] Depression / Mood
- [ ] Behavioral Difficulties
- [ ] Sensory Processing
- [ ] Motor Skills
- [ ] Autism Spectrum
- [ ] Intellectual Ability
- [ ] Other

How long have these concerns been present?

Who referred you?

What do you hope to gain from this evaluation?

5 Educational History

Did the child attend preschool or daycare?

○ Yes ○ No

Were there early concerns about learning or behavior?

○ Yes ○ No

If yes, please describe

Has the child ever been retained in a grade?

○ Yes ○ No

If yes, which grade?

Does the child currently have an IEP (Individualized Education Program)?

○ Yes ○ No ○ Unknown

Does the child currently have a 504 Plan?

○ Yes ○ No ○ Unknown

Has the child ever received special education services?

○ Yes ○ No

Services received (check all that apply)

- [ ] Speech-language therapy
- [ ] Occupational therapy (OT)

- [ ] Physical therapy (PT)
- [ ] Counseling / mental health
- [ ] Tutoring
- [ ] ABA therapy
- [ ] Other

Please describe other services

Additional details about services received

What is the child best at in school?

What are the child's greatest challenges at school?

Extracurricular activities

6 Developmental History

Were there any complications during pregnancy?

○ Yes ○ No

If yes, please describe

Was the child born full-term?

○ Yes ○ No

If not full-term, please describe (e.g., weeks premature, NICU stay)

Were there any complications at birth?

○ Yes ○ No

Developmental Milestones (approximate age reached)

First words

First sentences

Walking independently

Toilet training

Were there any early developmental concerns?

7 Medical History

Does the child have any known medical conditions?

○ Yes ○ No

If yes, please describe

Current Medications

Has the child experienced any head injuries or concussions?

○ Yes ○ No

If yes, please describe (when, how, severity, treatment)

Current or lingering symptoms since the injury (check all that apply)

- ☐ Headaches
- ☐ Dizziness / Balance problems
- ☐ Difficulty concentrating
- ☐ Memory problems
- ☐ Slower processing speed
- ☐ Fatigue / Low energy
- ☐ Irritability / Mood changes
- ☐ Sensitivity to light or noise
- ☐ Sleep disturbance
- ☐ Difficulty with word-finding
- ☐ Personality / Behavior changes
- ☐ Academic decline after injury
- ☐ Vision changes
- ☐ Anxiety or depression since injury

Date of last physical exam

Known vision problems?

Known hearing problems?

Date of last vision / hearing screening

8 Behavioral & Emotional History

Does your child display any of the following? (check all that apply)

- ☐ Difficulty following directions
- ☐ Easily distracted
- ☐ Difficulty staying seated
- ☐ Fidgety or restless
- ☐ Difficulty waiting turn
- ☐ Acts without thinking
- ☐ Difficulty making friends
- ☐ Withdrawn or isolated
- ☐ Excessive worry or fear
- ☐ Frequent crying or sadness
- ☐ Irritability or anger outbursts
- ☐ Aggression toward others
- ☐ Defiance or oppositional behavior
- ☐ Difficulty with transitions
- ☐ Repetitive behaviors or interests
- ☐ Difficulty reading social cues
- ☐ Low self-esteem
- ☐ Sleep difficulties
- ☐ Difficulty with organization
- ☐ Avoids schoolwork or homework

Additional details about concerning behaviors

Significant life events or stressors

Has the child received any mental health treatment?

○ Yes ○ No

If yes, please describe (type, provider, duration, current status)

Has the child had any previous psychological or educational testing?

○ Yes ○ No

If yes, please describe (what was assessed, when, results)

9 Strengths & Interests

What are the child's greatest strengths?

Hobbies and activities the child enjoys

How would you describe your child's personality?

Three positive qualities you most admire in your child

10 Additional Information

Is there anything else you would like Kristen to know before the evaluation?

May Kristen contact the child's school as part of the evaluation?

○ Yes ○ No

May Kristen contact the child's other providers (e.g., therapist, pediatrician)?

○ Yes ○ No

11 Acknowledgment & Signature

I certify that the information provided in this form is accurate and complete to the best of my knowledge.

Parent / Guardian Signature

Date

Printed Name

Relationship to Child