

# Comprehensive Adopted Child History Form

## GENERAL INFORMATION:

Today's Date: \_\_\_\_\_  
mm/dd/yyyy

Child's legal name: \_\_\_\_\_  
First Middle Last

Nickname: \_\_\_\_\_

Gender:  Male  Female

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Grade: \_\_\_\_\_

Religion: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_

Language(s) spoken in home: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

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

Email Address(es): \_\_\_\_\_

Name of person completing this form: \_\_\_\_\_

Relationship to patient:  Mother  Father  Other: \_\_\_\_\_

Parent Name: \_\_\_\_\_  
First Middle Last

Date of Birth: \_\_\_\_\_ Highest Grade Completed: \_\_\_\_\_  
mm/dd/yyyy

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

Parent Name: \_\_\_\_\_  
First Middle Last

Date of Birth: \_\_\_\_\_ Highest Grade Completed: \_\_\_\_\_  
mm/dd/yyyy

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

Marital status of parents:  married  never married  separated  divorced  widowed

Additional caregiver(s):  None or Name: \_\_\_\_\_

Relationship (nanny, grandparent, etc.): \_\_\_\_\_

How much time does this person spend with your child? \_\_\_\_\_

**Who lives in the Child's household?**

<b>Name:</b>	<b>Age:</b>	<b>Male / Female</b>	<b>Relationship to child:</b>
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	

**Name of pediatrician or family doctor:**

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

**Who referred your child to me?**

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

**Please list any services your child is currently receiving (speech, occupational therapy, tutoring, etc.):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CURRENT CONCERNS:**

**Please check the areas below that you have concerns about your child.**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> short attention span       | <input type="checkbox"/> attention seeking              | <input type="checkbox"/> distractibility    |
| <input type="checkbox"/> impulsivity                | <input type="checkbox"/> hyperactivity                  | <input type="checkbox"/> avoidance          |
| <input type="checkbox"/> low frustration tolerance  | <input type="checkbox"/> noncompliance                  | <input type="checkbox"/> skipping school    |
| <input type="checkbox"/> oppositional behavior      | <input type="checkbox"/> social isolation               | <input type="checkbox"/> anxiety            |
| <input type="checkbox"/> aggression                 | <input type="checkbox"/> lying                          | <input type="checkbox"/> stealing           |
| <input type="checkbox"/> setting fires              | <input type="checkbox"/> obsessive/compulsive behaviors | <input type="checkbox"/> cruelty to animals |
| <input type="checkbox"/> sensitivity to environment | <input type="checkbox"/> temper tantrums                | <input type="checkbox"/> cries easily       |
| <input type="checkbox"/> overly shy                 | <input type="checkbox"/> difficulty with transition     | <input type="checkbox"/> clingy to parent   |
| <input type="checkbox"/> irritable/inconsolable     | <input type="checkbox"/> attachment difficulties        | <input type="checkbox"/> hoarding behaviors |

Please explain all checked boxes: \_\_\_\_\_

Do you have concerns regarding your child's ability to form an attachment with you?

No  Yes, explain: \_\_\_\_\_

Describe any concerns not listed above: \_\_\_\_\_

When did you first notice these problems? \_\_\_\_\_

What do you hope to address by coming to see Dr. Forrester? \_\_\_\_\_

Note specific services (if any) you are seeking: \_\_\_\_\_

**ADOPTION INFORMATION:**

Date of adoption: \_\_\_\_\_ Age of child at adoption: \_\_\_\_\_

International adoption?  Yes  No

Place of adoption: \_\_\_\_\_

Was your child in a:  Foster Home  Orphanage  None  Other (explain: \_\_\_\_\_)

At what age did this child enter into your care? \_\_\_\_\_

Were the adoptive parents married/together at the time this child was adopted:  Yes  No

Length of adoptive parents' relationship at the time this child was adopted: \_\_\_\_\_

Are the adoptive parents currently together?  Yes  No

What adoption agency did you use? \_\_\_\_\_

How did you prepare for the adoption?  Internet  Classes  Books  Other: \_\_\_\_\_

Please list any websites, books or classes you found particularly helpful: \_\_\_\_\_

Was it what you expected?  Yes  No

explain: \_\_\_\_\_

Did you feel you were aware of the potential risks?  Yes  No

explain: \_\_\_\_\_

Did either parent experience the "adoption blues"?  Yes  No

explain: \_\_\_\_\_

Did either parent experience Post-Adoption Depression Syndrome (PADS)?  No  Yes

explain: \_\_\_\_\_

Have you ever considered disruption?  No  Yes

explain: \_\_\_\_\_

Does your child know he/she is adopted?  No  yes, what was he/she told? \_\_\_\_\_

Please add any additional information regarding the adoption of this child:

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

**PRE-NATAL HISTORY:**

Check here if no information is available regarding pre-natal history.

**Please answer the following questions to the best of your ability regarding pre-natal history.**

Did the birth mother have any other full-term pregnancies?  Yes  No  Unknown

Did the birth mother have any miscarriages, stillbirths or abortions?  Yes  No  Unknown

Was the birth mother married during this pregnancy?  Yes  No  Unknown

Did the birth mother receive pre-natal care during this pregnancy?  Yes  No  Unknown

Does this child have any biological siblings?  Yes  No  Unknown

If yes, is he/she aware of them?  No  Yes (what was he/she told: \_\_\_\_\_)

Is the birth mother listed on the register (Russia)?  Yes  No  Unknown

Please add any information regarding pre-natal history: \_\_\_\_\_

Check Yes / No for the items below that you are aware may have occurred during pregnancy:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Edema (swelling)	<input type="checkbox"/>	<input type="checkbox"/>	Accidents / Injuries
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Breathing difficulties
<input type="checkbox"/>	<input type="checkbox"/>	Toxemia	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol used
<input type="checkbox"/>	<input type="checkbox"/>	Emotional stress	<input type="checkbox"/>	<input type="checkbox"/>	Cigarettes used
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal weight gain
<input type="checkbox"/>	<input type="checkbox"/>	Infections (cold, flu, urinary)	<input type="checkbox"/>	<input type="checkbox"/>	Pre-term labor
<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization
<input type="checkbox"/>	<input type="checkbox"/>	Medication used	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Operations/Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	Other (explain below)

Please explain all "yes" answers: \_\_\_\_\_

\_\_\_\_\_

**BIRTH HISTORY:**

Check here if no information is available regarding birth history.

Where was the baby born? (city/state/country) \_\_\_\_\_

Was the baby born on time?  Yes  No ( early or  late? By how many weeks? \_\_\_\_\_)

Weight of child at birth: \_\_\_\_\_ Apgar scores (if known): \_\_\_\_\_

Age of biological mother at birth: \_\_\_\_\_ Age of biological father at birth: \_\_\_\_\_

**Check all that you are aware may apply:**

- spontaneous labor
- vaginal delivery
- toxemia/eclampsia
- induced labor
- c-section (planned:  yes  no)
- maternal fever
- breech presentation
- VBAC (vaginal birth after c-section)
- fetal distress
- medication used
- natural birth
- other (describe below)

Please add any comments regarding the items noted above: \_\_\_\_\_

**POST-DELIVERY PERIOD:**

Check here if no information is available regarding post-delivery history.

How many days did the baby stay in the hospital after birth? \_\_\_\_\_

How many days did the birth mother stay in the hospital after delivery? \_\_\_\_\_

Check Yes / No for the items that you are aware may have occurred during the days following the child's birth:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Infection
<input type="checkbox"/>	<input type="checkbox"/>	Need for ventilation	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Poor feeding
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding in head	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting / Reflux
<input type="checkbox"/>	<input type="checkbox"/>	Water on the brain	<input type="checkbox"/>	<input type="checkbox"/>	Floppy muscle tone
<input type="checkbox"/>	<input type="checkbox"/>	Turned blue	<input type="checkbox"/>	<input type="checkbox"/>	Neonatal ICU (NICU)
<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Other (explain below)

Please explain all "yes" answers: \_\_\_\_\_  
 \_\_\_\_\_

**DEVELOPMENT:**

Did your child have colic?

No  Yes, from age \_\_\_\_\_ until age \_\_\_\_\_

Did your child experience any feeding problems?

No  Yes, describe: \_\_\_\_\_

Does your child experience any feeding problems now?

No  Yes, describe: \_\_\_\_\_

**Check items below which may have occurred during the first few years of life:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> difficult to comfort   | <input type="checkbox"/> excessive restlessness | <input type="checkbox"/> extended crying        |
| <input type="checkbox"/> excessive irritability | <input type="checkbox"/> sleep difficulties     | <input type="checkbox"/> extremely passive      |
| <input type="checkbox"/> always had to be held  | <input type="checkbox"/> frequent head banging  | <input type="checkbox"/> other (describe below) |

Please explain all "yes" answers: \_\_\_\_\_  
 \_\_\_\_\_

**Please complete the chart below regarding your child's accomplishment of early developmental milestones:**

<i>Milestone</i>	<i>Age milestone accomplished</i>	<i>Did you feel this was:</i>
Smiled (social smile)		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Laughed		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Rolled over		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Sat independently		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Crawled independently		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Stood independently		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Walked independently		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Waved bye-bye		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Toilet trained (urine)		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Toilet trained (bowel)		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Spoke first words		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Put two words together		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late

What were your child's first words? \_\_\_\_\_

Could you understand your child's speech by age 2 years?  Yes  No

Could others understand your child's speech by age 2 years?  Yes  No

Could your child speak in simple sentences by age 2 years?  Yes  No

Did your child speak in his/her native language prior to adoption?  Yes  No

If yes, did he/she use:  single words  word combinations

How does your child typically communicate now:  gesture  words  sentences

What is your child's sleeping arrangement?  Room alone  With sibling  Parents room  Other

Where does your child sleep?  Crib  Bed  Parents bed  Other: \_\_\_\_\_

Is it difficult for your child to go to sleep?  No  Yes, describe: \_\_\_\_\_

How long does it take him/her to fall asleep? \_\_\_\_\_

Do you have a regular bedtime routine?  No  Yes, describe: \_\_\_\_\_

Does your child wake up during the night?  No  Yes (how many times? \_\_\_\_\_)

How long does he/she stay awake? \_\_\_\_\_ What helps him/her go back to sleep? \_\_\_\_\_

Is your child a restless sleeper?  No  Yes, describe: \_\_\_\_\_

Does (Did) your child have a special object (blanket, teddy bear

No  Yes, describe: \_\_\_\_\_ Until age: \_\_\_\_\_

Does (Did) your child have any self-soothing behavior (e.g., suck thumb, pacifier, twirl hair, etc.)?

No  Yes, describe: \_\_\_\_\_ Until age: \_\_\_\_\_

How many hours of screen time (TV, video games, etc.) does your child have each day? \_\_\_\_\_

What are his/her favorites? \_\_\_\_\_

### **TEMPERAMENT:**

I would like to get a sense of how you would describe your child's temperament. Please describe his/her temperament using adjectives below:

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

#### **Check the type of discipline you use with your child:**

rewards  time out (isolation)  avoidance of child

verbal reprimands  removal of privileges  physical punishment

Which form of discipline has proven most effective? \_\_\_\_\_

How often must you discipline your child? \_\_\_\_\_

What is the most common reason for discipline? \_\_\_\_\_

Does your child have any close friends?  No  Yes (how many? \_\_\_\_\_)

Does your child get along well with his/her peers?  Yes  No, describe: \_\_\_\_\_

Does your child make new friends easily?  Yes  No, describe: \_\_\_\_\_

Does your child get along best with children that are:  same age  younger  older

Please add any comments regarding your child's peer relationships: \_\_\_\_\_

**Please check if your child is:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> loud and noisy     | <input type="checkbox"/> easily angered         | <input type="checkbox"/> able to entertain him/herself |
| <input type="checkbox"/> sensitive to sound | <input type="checkbox"/> shy with new adults    | <input type="checkbox"/> affectionate                  |
| <input type="checkbox"/> sensitive to touch | <input type="checkbox"/> shy with new children  | <input type="checkbox"/> aggressive                    |
| <input type="checkbox"/> sensitive to light | <input type="checkbox"/> physically cautious    | <input type="checkbox"/> sluggish/slow moving          |
| <input type="checkbox"/> sensitive to smell | <input type="checkbox"/> a dangerous risk taker | <input type="checkbox"/> overly active                 |

Please explain all above checked boxes: \_\_\_\_\_

What are your child's favorite activities? \_\_\_\_\_

What are your child's least favorite activities? \_\_\_\_\_

Describe your child's typical mood: \_\_\_\_\_

What about your child makes you most proud? \_\_\_\_\_

**CHILD'S HEALTH HISTORY:**

**Check Yes / No for the items below which your child may have experienced:**

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	Pica (eating nonfood items)
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	Excessive vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Head trauma
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Loss of consciousness
<input type="checkbox"/>	<input type="checkbox"/>	Stomach aches	<input type="checkbox"/>	<input type="checkbox"/>	Coma
<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	Tics
<input type="checkbox"/>	<input type="checkbox"/>	Stool soiling	<input type="checkbox"/>	<input type="checkbox"/>	Staring spells
<input type="checkbox"/>	<input type="checkbox"/>	Chronic ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Tremor
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	Frequent falls
<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Broken bones, stitches	<input type="checkbox"/>	<input type="checkbox"/>	Persistent high fever
<input type="checkbox"/>	<input type="checkbox"/>	Accidental poisoning	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Floppy muscle tone	<input type="checkbox"/>	<input type="checkbox"/>	Other problems (explain)

Please explain all "yes" answers: \_\_\_\_\_

Do you have any particular concerns regarding your child's physical health?

No  Yes, explain: \_\_\_\_\_

Does your child currently take medication?

No  Yes, list: \_\_\_\_\_

List any medications your child has taken in the past: \_\_\_\_\_

When was your child's last physical exam? \_\_\_\_\_ Where? \_\_\_\_\_

Please check if your child has had any of the following or  None

- Individual Psychotherapy       Group Psychotherapy       Occupational Therapy
- Physical Therapy       Speech Therapy       Developmental Evaluation
- Educational Evaluation       Brain scan (CT or MRI)       EEG testing
- Genetic/Chromosome tests       Lead testing       Other (explain: \_\_\_\_\_)

Please explain all checked boxes including dates, providers, and results: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**BIOLOGICAL FAMILY HEALTH HISTORY:**

Check here if no information is available regarding biological family health history.

Check Yes / No for each item below that may apply to a family member and then state relation (e.g., mother, brother, paternal uncle, maternal cousin, etc.)

Yes	No		<i>Relation to child:</i>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	
<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects	
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	
<input type="checkbox"/>	<input type="checkbox"/>	Genetic Condition	
<input type="checkbox"/>	<input type="checkbox"/>	Muscle/Motor Problem	
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe: _____ )	

Please add any relevant details you feel are important regarding items above: \_\_\_\_\_  
\_\_\_\_\_

Are there any other health issues that run in the family?  No  Yes, explain: \_\_\_\_\_  
\_\_\_\_\_



**BIOLOGICAL FAMILY EMOTIONAL AND LEARNING HISTORY:**

Check here if no information is available regarding biological family emotional / learning history.

Check Yes / No for each item below that may apply to a family member and then state relation (e.g., mother, brother, paternal uncle, maternal cousin, etc.)

Yes	No		Relation to child:
<input type="checkbox"/>	<input type="checkbox"/>	Depression	
<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	
<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity/ADHD	
<input type="checkbox"/>	<input type="checkbox"/>	Oversensitivity to Sound/Touch/Taste/Smell	
<input type="checkbox"/>	<input type="checkbox"/>	Learning Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Autism Spectrum Disorder	
<input type="checkbox"/>	<input type="checkbox"/>	Speech Problems/Delays	
<input type="checkbox"/>	<input type="checkbox"/>	Eating Problems (Anorexia, Bulimia)	
<input type="checkbox"/>	<input type="checkbox"/>	Post-Partum Depression	
<input type="checkbox"/>	<input type="checkbox"/>	Intellectual Disability	
<input type="checkbox"/>	<input type="checkbox"/>	Phobias/Fears	
<input type="checkbox"/>	<input type="checkbox"/>	Down Syndrome	
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	
<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia	
<input type="checkbox"/>	<input type="checkbox"/>	Obsessive Compulsive Disorder (OCD)	
<input type="checkbox"/>	<input type="checkbox"/>	Bipolar Disorder (Manic Depression)	
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe: _____ )	

Please add any relevant details you feel are important regarding items above: \_\_\_\_\_

Has any biological relative to your child experienced problems similar to those your child is currently experiencing?  No  Yes, explain: \_\_\_\_\_

**ADOPTIVE FAMILY HEALTH HISTORY:**

Please provide any information you feel is important regarding this child's adoptive family's health and emotional history: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**RECENT STRESSFUL EVENTS AND SUPPORT:**

Please check if either parent has experienced any of the following or  None

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Major accident/illness | <input type="checkbox"/> Moving homes                 | <input type="checkbox"/> Loss of significant other |
| <input type="checkbox"/> Financial setback      | <input type="checkbox"/> Loss of family member/friend | <input type="checkbox"/> Difficulty as a couple    |
| <input type="checkbox"/> Separation from child  | <input type="checkbox"/> Therapy/counseling           | <input type="checkbox"/> Other (explain: _____)    |

Please explain all checked boxes (What happened? When? What support did you have? How did you deal with it?): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please check if your child has experienced any of the following or  None

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Separation from parent | <input type="checkbox"/> Moving homes                 | <input type="checkbox"/> Addition of new sibling |
| <input type="checkbox"/> Major accident/illness | <input type="checkbox"/> Loss of family member/friend | <input type="checkbox"/> Other (explain: _____)  |

Please explain all checked boxes (What happened? When? How did your child react?):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SCHOOL/EDUCATION HISTORY:**

Does your child attend school/preschool/daycare?  No  Yes

Name of child's current school/preschool/daycare: \_\_\_\_\_

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

Telephone: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Director: \_\_\_\_\_ Special Placement (if any): \_\_\_\_\_

Please list the following information for each school/preschool/daycare your child has attended:

<i>Name</i>	<i>Age at entry</i>	<i>Begin date</i>	<i>End date</i>	<i>Hours per day &amp; Days per week</i>

**Please check all that apply to your child's preschool / daycare / school experience:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Adjustment problems       | <input type="checkbox"/> Negative reaction to school     | <input type="checkbox"/> Services through ECI       |
| <input type="checkbox"/> Services through PPCD     | <input type="checkbox"/> Services at school (speech, OT) | <input type="checkbox"/> Extra support in classroom |
| <input type="checkbox"/> Pull-outs (reading, math) | <input type="checkbox"/> School completed testing        | <input type="checkbox"/> IEP or ARD                 |
| <input type="checkbox"/> Repeated a grade          | <input type="checkbox"/> Asked to leave school/program   | <input type="checkbox"/> Suspended from school      |
| <input type="checkbox"/> Expelled from school      | <input type="checkbox"/> Performance below peer level    | <input type="checkbox"/> Other (explain: _____)     |

**Please explain all checked boxes:**

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**ADDITIONAL INFORMATION:**

Please add any additional information or address any concerns not addressed above:

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