Neuroeducation, Inc., P. C.
Psychological & Educational Evaluations & Treatment

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Were you were referred to us by: Doctor ( ) _____(name)
Teacher ( ), Friend ( ), Relative ( ), Other ( )_____

If not referred, how did you find us? Internet search ( ), Advertisement ( ),
Phone Book ( ), Other ( )_____

Today's Date_____

Child's Name_____ Birth Date_____ Age_____

Home Address_____City_____State/Zip_____

Home Phone_____ Cell Phone_____Email_____

Father's Name_____Occupation_____SSN_____

Mother's Name_____Occupation_____SSN_____

Medical Insurance_____Name of Insured_____DOB of Insured_____

Is child adopted? Yes/No At what age? _____ Does child know? ____Y ___N

Others living at home? (siblings, others) _____

Child living with: Both Parents Father Mother Stepfather Stepmother Foster Parents Other

Child is in Grade: _____ at what School? _____ Teacher's name_____

My/Our reasons for bringing child today are:

Motivation Attention Problems with siblings/other children Behavior

Reading difficulty Math difficulty Problems with eating/sleeping Worry

Other or Comment:_____

Problem has been going on for: weeks months year or more

Parents generally: agree disagree on how to discipline child.

Other children in the home have problems with: _____

Developmental History

Age held head up_____

Age crawled_____

Age walked_____

Speech problems?_____

Shy or timid as baby?_____

Friendly baby?_____

Fussy (Colicky)?_____

Eating habits as baby_____

Temper tantrums?_____

Too active?_____

Toilet trained when?_____

Right or left handed?_____

Others in family left handed? _____

Sleep habits when young?_____

Current Description

Current speech problems?_____

Shy or timid now? _____

Friendly now? _____ a "loner?"_____

Fussy or picky now?_____

Eating habits now?_____

Temper tantrums?_____

Too active now?_____

Problems wetting/soiling?_____

When was rt or lft hand apparent?_____

Coordination now:_____

Accident prone?_____

Bedtime is_____Cooperative?_____

Blank spells, fainting?_____

Medical History Child's Physician: _____

Has Your Child Had:

Epilepsy or seizures?_____

Speech or language problems_____

High fever (>103)_____

Abscessed ears_____

Broken bones or stitches_____

Allergies_____

Asthma_____

Seizures_____

Injuries to head_____

Hospitalizations_____

Extended illness (>1 month)_____

Any medical problems now?_____Medications your child is taking now?_____

_____

Have parents or child had previous counseling?_____

School History: Problem areas according to school personnel (circle answers below)

Behavior speech math reading listening writing spelling attention

Other concerns:_____

Child has had: special education (IEP or 504) tutoring resource room

Child's attitude towards school: likes dislikes indifferent

Has child repeated a grade? _____ Which one?_____ Has it helped?_____

Legal Involvement:

Are there any current or past legal actions involving this child? _____

If 'yes', please check all that apply: __Child Protective Services __Divorce/Custody __Truancy __Other

Personal Information:

How many times has your family moved since the child's birth? _____

Has religious faith been important in your child's life?_____

Has your child had any very stressful or traumatic experiences?_____

Your signature_____ Date_____

Print Your Name_____