**JUNE SHELTON SCHOOL and EVALUATION CENTER**
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## Questionnaire for Child and Adolescent Clients

Please complete this form to help in understanding the client referred to us. If extra space is needed, please feel free to attach additional pages for your comments.

Date: ________________________

Referred by ____________________________________________________________

Who completed this form? ______________________________________________

**I. IDENTIFYING INFORMATION**

Client's Name______________________________________Sex _________ Age __________

Date of Birth ___________________ School _____________________________________

Current Grade __________________

Client lives with ______________________________________________________________

at _____________________________________________________________________
(Address, City, State, Zip code)

______________________________ ________________________ __________________________
(Area Code & Home Phone Number) (Cell Phone Number) (E-mail Address)

* Best number to use in order to contact you ___________________________________________

**List names, as appropriate:**

Father ______________________________ Step-father ____________________________

Mother _____________________________ Step-mother ___________________________

Are parents separated? If so, for how long? _____ Are parents divorced? If so, for how long? ______

How often does the child visit the non-resident parent? _____________________________________

**Present employment of resident parents:**

Father _____________________________________________ Business phone __________________

Mother _____________________________________________ Business phone __________________

**II. PURPOSE OF THIS EVALUATION:**

What questions are to be answered by this evaluation? ______________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

This client's strengths include: ___________________________________________________________

_______________________________________________________________________________

This client's main problems are: ______________________________________________

______________________________________________

What are the teacher's concerns?______________________________________________

______________________________________________

Does client have any difficult to manage behaviors? ______________________________

______________________________________________

Does client have any behavior that you consider unique or different compared to most children you know? ______________________________________________

______________________________________________

**III. DEVELOPMENTAL HISTORY**

A. Was this client adopted? ____________ If yes, age at time of adoption ____________

Date of adoption ____________ Location of adoption ____________

B. Mother's medical history during pregnancy:

1. Was this pregnancy a result of IVF? ______________________________

2. Were there any difficulties during pregnancy? ____________ If so, please describe:

______________________________________________

______________________________________________

______________________________________________

3. Were there any medications taken during the pregnancy? __________ If so, what kind?

______________________________________________

4. Were there any accidents during the pregnancy? ______________ If so, please describe:

______________________________________________

5. Were there any emotional pressures during the pregnancy? ____________ If so, please describe:

______________________________________________

______________________________________________

**IV. EARLY HISTORY FOR THIS CLIENT**

1.Where was this client born?______________________________________________

2. Length of pregnancy________________ Length of labor ____________

3.Were there any difficulties during labor or delivery? __________ If so, what kind?

______________________________________________

______________________________________________

4. Was delivery by Cesarean section?______________________________

5. Weight at birth ________lbs. __________oz.

6. Was the client healthy at birth? ____________If not, please describe:____________

______________________________________________

______________________________________________

7. Did the client require a stay in the NICU? __________ If so, for how long? ____________

8. Was the client contented or fretful as an infant? ______________________________________

9. Did the infant experience any difficulty establishing sleeping or eating habits? _____________
_______________________________________________________________________________

10. Were any medications prescribed in the first year? If so, what was prescribed and why?
_______________________________________________________________________________
_______________________________________________________________________________

11. Was the client involved in speech-language therapy and/or OT/PT during the first few years of life? _______ If so, why? ______________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

**V. DEVELOPMENTAL HISTORY**

When did the client reach the following milestones?

Crept or crawled? _______________________________________________________________

Walked unattended? _____________________________________________________________

First words spoken? _____________________________________________________________

Talked in short sentences? ________________________________________________________

Talked clearly enough that strangers understood? ______________________________________

Became toilet trained (easily/difficult)? _____________________________________________

Learned to skip? ________________________________________________________________

Began bicycle riding without training wheels? _________________________________________

**VI. MEDICAL HISTORY**

1. Has the client had any serious illnesses? Did this require hospitalization? ___________________
_______________________________________________________________________________
_______________________________________________________________________________

2. Did the client have a history of ear infections? If so, how many? __________________________

Were they treated with pressure equalizing tubes? _______If so, at what age(s)? _________________

3. Is there a history of seizures? ______________________________________________________

4. Is there a history of head injury? ___________ Concussion? __________ If so, when?__________
_______________________________________________________________________________

5. Is there a history of allergies? _____________________________________________________

6. Please describe any other medical conditions: ________________________________________
_______________________________________________________________________________

7. Describe any serious accidents the client has had: _____________________________________
_______________________________________________________________________________

8. Who is the client's primary physician? _______________________________________________
_______________________________________________________________________________

9. When was the client's last physical examination? ______________________________________

What were the results?________________________________________________________________

10. Is the client prescribed any medication? __________ If so, what is prescribed and what dosage?

________________________________________________________________________________

________________________________________________________________________________

Have there been any other medications taken in the last twelve months?_________________________

________________________________________________________________________________

11. Hearing has/has not been checked:

at school _________; in doctor's office _________; by an Audiologist _________ Date __________

Results: adequate/inadequate. If inadequate, please explain _________________________________

________________________________________________________________________________

12. Vision has/has not been checked:

at school _________; in doctor's office _________; by an ophthalmologist/optometrist __________

Date __________

Results: adequate/inadequate. If inadequate, please explain _________________________________

________________________________________________________________________________

13. Is this client on a special diet? __________ If so, what kind? ____________________________

________________________________________________________________________________

## VII. FAMILY HISTORY

1. List by name the members of this client's family. Please include parents, full, and half siblings.

| Name of Family Member | Relationship to This Client | Age | Highest Year of School Completed | Reading, Writing, Math, Speech/ Language or Attention Problems? If so, which and when? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

2. Please note a history of the following difficulties in both immediate or extended family.

| Illness/Difficulty | Check if Yes | When Occurred | Relationship to Client (e.g., maternal aunt) |
|---|---|---|---|
| Hospitalization for Emotional Problems | | | |
| Bi-Polar Disorder | | | |
| Schizophrenia | | | |
| Intellectual Disability | | | |
| Drug Addiction | | | |
| | | | |

| Illness/Difficulty | Check if Yes | When Occurred | Relationship to Client (e.g., maternal aunt) |
|---|---|---|---|
| Criminal Record | | | |
| Depression | | | |
| Anxiety | | | |
| Speech or Articulation Difficulty | | | |
| Reading, Writing, Spelling Problems | | | |
| Attention Problems or Hyperactivity | | | |
| Autism Spectrum Disorder (Asperger's Syndrome), PDD, NOS | | | |

**VIII. SCHOOL HISTORY**

1. Did the client attend a preschool program? __________ If so, where? ______________________

______________________________________________________________________________

What ages? __________________________________

2. List the names of schools attended beginning with kindergarten:

| School Name | Client's Age | Grade | City/State | School System (public/private) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

3. Was entry into first grade delayed by attending a primer class or kindergarten twice?

______________________________________________________________________________

4. Please provide information about current school placement:

a. Has the teacher reported any concerns? ______________________________________________

______________________________________________________________________________

______________________________________________________________________________

b. The client's best subjects are: ______________________________________________________

c. Does the client have any specific difficulties in school? ______________________ If so, what?

______________________________________________________________________________

______________________________________________________________________________

d. What are the most recent grades? __________________________________________________

______________________________________________________________________________

e. Does the client have difficulty with the following:

Finishing his/her work in class? ____________________

Staying in his/her seat when asked? ____________________

Working independently? ____________________

f. Describe the homework process. ____________________

____________________

____________________

g. Does the client like school? ____________________

____________________

h. What does the teacher think about the client's behavior? (general attitude, response when corrected, relationships with classmates, etc.) ____________________

____________________

____________________

i. Has the client received speech therapy and/or OT/PT during the school years? __________

If so, for how long? ____________________

j. Is the client receiving any support in the school (504, IEP, Gifted)? ____________________

If so, describe the services offered (speech therapy, occupational or physical therapy, resource room, etc.) ____________________

____________________

____________________

____________________

k. Is the client served under Response To Intervention ?____________________

l. Is the client currently begin tutored? ____________________

m. Has the client had testing before? If so, by whom and what were the conclusions? __________

____________________

____________________

## IX. BEHAVIOR

1. Describe the client's sleep habits. ____________________

____________________

____________________

2. Does the client have a history of nightmares or night terrors? ____________________

____________________

3. Describe the client's eating habits. ____________________

____________________

____________________

4. Does the client have difficulty with:

| | What Age(s) |
|---|---|
| Being bullied | ______________________________ |
| Bullying others | ______________________________ |
| Shyness | ______________________________ |
| Hair twisting/pulling out hair | ______________________________ |
| Thumb sucking | ______________________________ |
| Nail biting | ______________________________ |
| Clumsiness, trouble with gross motor skills | ______________________________ |
| Tying shoes, cutting, catching a ball | ______________________________ |
| Excessive demands | ______________________________ |
| Peer relationships/social skills | ______________________________ |
| Excessively focused on specific interests | ______________________________ |
| Fear of darkness | ______________________________ |
| Restlessness | ______________________________ |
| Daydreaming | ______________________________ |
| Truancy | ______________________________ |
| Fighting | ______________________________ |
| Temper tantrums | ______________________________ |
| Resenting discipline | ______________________________ |
| Eating issues | ______________________________ |
| Sensitivity to textures | ______________________________ |
| Other (please describe) | ______________________________ |

5. Has this client ever had contact with the police or juvenile authorities? If so, please explain.

______________________________________________________________________________

______________________________________________________________________________

6. Have you or a teacher or pediatrician ever been concerned about an autism spectrum disorder?

______________________________________________________________________________

______________________________________________________________________________

7. Please describe any unusual behavior patterns your child possesses either positive or negative.

______________________________________________________________________________

______________________________________________________________________________

8. Is the client easy or difficult to manage? ____________ Do parents agree? ______________________

9. Does he/she have regular chores? __________________________________________________________

______________________________________________________________________________

10. What activities does the family do together? _________________________________________

______________________________________________________________________________

11. Describe how this client gets along with:
Father ____________________________________________
Mother ____________________________________________
Brothers ____________________________________________
Sisters ____________________________________________
Step-family members in the home ______________________________
12. The client seems to get most upset when ______________________________
____________________________________________
13. The client seems happiest when ______________________________
____________________________________________

## X. SOCIAL INTERACTION

1. This client has (many, average, few, no) friends. ______________________

2. In social activities, this child most often prefers the company of others (younger, older, his/her own age). ______________________________

3. If he/she could, he/she would like to have (many, few) friends; do things (alone, with just one friend, in a group). ______________________________

4. This child likes best to socialize (at home, at someone else's house).______________

5. Please select any behaviors that are observed in this client

_____ appears uninterested or does not ask about opinions, comment, thoughts or perspective of others?

_____ has poor eye contact during conversations or play?

_____ seems unaware of the "unwritten rules" of social play?

_____ has a very serious or pedantic way of talking, like a college professor or a "walking dictionary?"

_____ speaks loudly or has an unusual cadence or tone of voice?

_____ does not understand jokes or figures of speech, or interprets too literally (i.e. "kick the bucket?")

_____ seems fascinated and/or very knowledgeable about particular subjects (i.e. Thomas the Tank Engine, Dinosaurs, Pokemon, YugiOh cards, Star Wars, etc.)?

_____ becomes upset by changes in routine, or requires much reassurance if things change or go wrong?

_____ lines up objects or has rituals or routines that must be followed precisely?

_____ acts like he/she is not hearing but can be very sensitive to certain common sounds (puts hands over ears when appliances are turned on)?

_____ difficulty with or lack of interest in maintaining friendships?

_____ has sensitivities to textures or specific food items?

_____ stares at lights, fans or looks at objects at odd angles?

_____ odd motor mannerisms? (hand flicking, head banging, turning objects)

6. What does she/he like to do for recreation? ________________________________________________
_____________________________________________________________________________________

7. Please list any extracurricular activities that the client participates in. _________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

8. What plans do you have for changes in such areas as family, school, social, medical, etc., that have not been mentioned elsewhere in this questionnaire?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**XI. OTHER SPECIALISTS CONSULTED**

1. Name ____________________________________________________ Date ____________________
Findings __________________________________________________________________________
_____________________________________________________________________________________

2. Name ____________________________________________________ Date ____________________
Findings __________________________________________________________________________

3. Please add any additional information you feel will be helpful to us.
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**PLEASE INCLUDE COPIES OF ALL PREVIOUS EVALUATION REPORTS, COPIES OF ANY STANDARDIZED TESTING (STAAR, SAT/ACT, ISEE ETC.) AND ANY 504 OR SPECIAL EDUCATION PAPERWORK.**