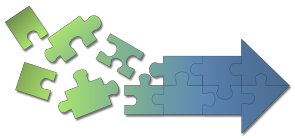

Forward Thinking Assessment

Comprehensive ● Individualized ● Collaborative

Developmental History

Today's Date: _____

Patient Name:_____
First Middle Last

Date of Birth: _____ **Gender:**_____

Person Completing this Form:_____

Please describe your main concern: _____

_____

_____

Family Information

	Parent	Parent
Name/Relationship	_____	_____
Level of Education	_____	_____
Occupation	_____	_____
Employer	_____	_____
History of ADHD?	_____	_____
History of learning disorder?	_____	_____
Depression/anxiety?	_____	_____
Other diagnosis?	_____	_____
Substance use problems?	_____	_____

Parents are: [ ] Married [ ] Separated [ ] Divorced

[ ] Not married but live together [ ] Not married and do not live together

Please list any step-parents or other significant adults: _____

_____

Please list any siblings or half-siblings:

Name	Age	Relationship	History of ADHD/Learning Disorder/Other Diagnosis

Please list any other people who live in the home:_____

_____

Is there any extended family history of ADHD, learning disorders, depression, anxiety, bipolar disorder, autism spectrum disorder/Asperger's Disorder, schizophrenia, or substance abuse?

_____

_____

Please describe any significant family or outside stressors that may be affecting your child:

_____

_____

Developmental History

Was your child adopted? [ ] Yes [ ] No

Length of Pregnancy: _____ Birth Weight: _____

Did the mother use any of the following substances while pregnant?
[ ] Caffeine [ ] Cigarettes [ ] Alcohol [ ] Illegal Drugs
[ ] Over the counter medications: _____
[ ] Prescription medications: _____

Please describe any complications during the pregnancy: _____

_____

Type of delivery: [ ] Vaginal [ ] Caesarean Section

Please describe any complications during labor or delivery: _____

_____

Did your child experience any delays in:
[ ] Motor development
[ ] Language development
[ ] Toilet training

If so, please explain: _____

_____

Did your child receive any early intervention services? Please explain: _____

_____

Medical History

Primary Care Physician:_____ Phone:_____

Does your child have any:	Medical problems?	[ ] Yes	[ ] No
	Vision problems?	[ ] Yes	[ ] No
	Hearing problems?	[ ] Yes	[ ] No

If so, please describe_____

Has your child ever been hospitalized? [ ] Yes [ ] No

If so, please describe_____

Is your child currently or has your child been under the care of any other health professionals?
[ ] Yes [ ] No

If so, who?_____

Is your child currently or has your child participated in therapy or counseling services?
[ ] Yes [ ] No

If so, with whom?_____

Has your child ever been given a psychological diagnosis?
[ ] Yes: _____
[ ] No

Please list any medications your child is currently taking:

Medication Name	Dosage	Prescribing Physician	Any side effects?

Has your child previously taken any psychiatric medications not listed above? _____

_____

Has your child ever been the victim of physical abuse?	[ ] Yes	[ ] No
Has your child ever been the victim of sexual abuse?	[ ] Yes	[ ] No
Has your child ever been the victim of emotional abuse?	[ ] Yes	[ ] No
Has your child ever been the victim of neglect?	[ ] Yes	[ ] No
Has there ever been Child Protective Services involvement?	[ ] Yes	[ ] No

If so, please explain_____

Do you have any concerns that your child may be using cigarettes, alcohol, or illegal drugs?
[ ] Yes If yes, please explain:_____
[ ] No

Academic History

Current School: _____ Grade Level:_____

Teacher's Name (if applicable): _____

Please list all schools attended, beginning with preschool:

School Name	Grade Levels

Has your child ever skipped a grade? [ ] Yes [ ] No
Has your child ever been retained? [ ] Yes [ ] No
Has your child received tutoring services? [ ] Yes [ ] No
Has your child been evaluated for learning problems? [ ] Yes [ ] No

If so, please describe the findings: _____

What is your child's best subject? _____

In what area does your child have the most difficulty? _____
Is your child currently having academic difficulty? [ ] Yes [ ] No
Is your child experiencing behavioral problems in school? [ ] Yes [ ] No
Has your child ever been suspended? [ ] Yes [ ] No
Has your child ever been expelled? [ ] Yes [ ] No

If yes to any of the above, please describe: _____

_____

Does your child have a Section 504 Plan [ ] Yes [ ] No
Individualized Education Plan (IEP) [ ] Yes [ ] No
Student support plan of any kind [ ] Yes [ ] No

Please describe the services your child receives: _____

_____

Social Information

Briefly describe your child's personality:_____

_____

Please list any extracurricular activities: _____

_____

_____

Does your child have any difficulty [ ] Making friends [ ] Keeping friends

Do you have any concerns about your child's social development: _____

_____

_____

Please describe any concerns about your child's current behavior: _____

_____

_____

Is there any other information you feel would be helpful or relevant? _____

_____

_____