

Name of person <i>completing form</i> :	Date <i>form completed</i> :																														
Child's Name: _____ Birth Date: ___/___/___ Age: _____ Address: _____ _____ City: _____ State: ___ ZIP: _____ Current School: _____ Grade Level: _____ Primary language(s) at home: _____ _____ Race/Ethnicity (optional): _____	What would you like answered or addressed by the evaluation? _____ _____ _____ _____ _____ _____																														
<div style="text-align: center;"><b>Parent 1</b></div> Name: _____ Birth Date: ___/___/___ Age: _____ Relationship to Child: _____ Occupation: _____ Address: _____ City: _____ State: ___ Zip: _____ Phone: (____) _____ Highest grade completed: _____ Best time to call: _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%; padding: 5px;">Any concerns in:</th> <th style="width: 15%; padding: 5px;">Yes/No</th> <th style="width: 25%; padding: 5px;">Age when noted:</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">How your child moves</td> <td style="width: 15%;"></td> <td style="width: 25%;"></td> </tr> <tr> <td style="padding: 5px;">Fine Motor Skills</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">Social Skills</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">School Success</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">Speech/Language</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">Attention</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">Feeding</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">Sleep</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">Behavior</td> <td></td> <td></td> </tr> </tbody> </table>	Any concerns in:	Yes/No	Age when noted:	How your child moves			Fine Motor Skills			Social Skills			School Success			Speech/Language			Attention			Feeding			Sleep			Behavior		
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<div style="text-align: center;"><b>Parent 2</b></div> Name: _____ Birth Date: ___/___/___ Age: _____ Relationship to Child: _____ Occupation: _____ Address: _____ City: _____ State: ___ Zip: _____ Phone: (____) _____ Highest grade completed: _____ Best time to call: _____	<div style="text-align: center;"><b>Primary Care Physician (PCP):</b></div> Name: _____ Address: _____ _____ Phone: _____ Fax: _____ Date child last seen: _____ <b><i>Before being scheduled with DBP, this child MUST have been seen by PCP within the last 6 months REGARDING THIS CONCERN</i></b>																														
<div style="text-align: center;"><b>GUARDIAN</b></div> <div style="text-align: center;"><small>Please complete only if not included above</small></div> Name: _____ Age: _____ Occupation: _____ Address: _____ City: _____ State: ___ Zip: _____ Phone: (____) _____ How long have you known child? _____ Best time to call: _____																															

Comments:

Milestone	Age
Walked	
Talked in single words	
Talked in short Sentences	
Sang a song	
Read simple words	
Did not need diapers during the day	
Did not need diapers at night	
Education Status	
IEP or Section 504 in place? (circle)	Yes/No
Does your child receive SSI? (circle)	Yes/No
Ever repeated a grade? (circle)	Yes/No
Number of suspensions/expulsions	#
Has your child ever received EI services or other therapies?	Yes/No
Ongoing therapies (with frequencies):	
Prior <i>Developmental</i> Evaluations	Date
Birth History	
Birth weight:	
Complications of pregnancy/birth:	
Hospitalizations/Surgeries:	
Previous Medical Diagnoses	Date
Current Medications	Dose
Past Medications	Dose

Please list any hobbies or extracurricular activities that your child enjoys:

Name/type of Insurance: \_\_\_\_\_

*If there is any additional information which you would like us to know or that may help us better understand your child, attach additional sheets, as needed.*