**CLIENT FORMS—RE-EVALUATION**
2018

Today's Date: _____ / _____ / _____ Person(s) completing this form _____

**Child information**

Child's Full Name _____

Child's Date of Birth _____ / _____ / _____ Age _____ Grade: _____

**Parent information (please CIRCLE best ways to reach parents)**

Circle those that apply: Biological parent Adoptive parent Other_____

Home phone number (if applicable) : _____

FULL Mailing Address: _____

**Parent 1 (P1) name**_____ cell number: _____

Email address _____

Highest grade completed: _____ Area of study:_____

Occupation (if home now, indicate that and previous occupation): _____

**Parent 2 (P2) name**_____ cell number: _____

Email address _____

Highest grade completed: _____ Area of study:_____

Occupation (if home now, indicate that and previous occupation):_____

**List Members of household and their ages:**

If divorced, please describe custody arrangement:

## SCHOOL INFORMATION

Name of school _____

Full Mailing Address _____

Phone number:_____

Teacher 1 name:_____

T1 email address:_____

**If applicable**
Teacher 2 name _____

T2 email address:_____

**If applicable:**
**Relevant School Personnel who are involved in supporting your child**
(i.e. reading, math, speech or occupational therapist, counselor, 504 coordinator, learning specialist, or administrator involved in supporting learning needs)

Specialist 1 name _____

S1 email address:_____

Specialist 2 name _____

S2 email address:_____

Specialist 3 name _____

S3 email address:_____

Specialist 4 name _____

S4 email address:_____

**Schools Attended**

| Grade | Name of School | If other than a change to do typical advancement, list reason for change: |
|---|---|---|
| Day care | | |
| Preschool | | |
| Junior K | | |
| K | | |
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |
| 6 | | |
| 7 | | |
| 8 | | |
| 9 | | |
| 10 | | |
| 11 | | |
| 12 | | |
| College | | |

**If you or your child's school has had any concerns about your child in relation to learning, please complete this page.**

Has this child ever repeated a grade? Yes No *(If so which one(s)?* _____*)*

Please describe the main difficulties since last seen. **This can include school and/or parent concerns.**

Please circle any of the following that your child has had since last seen:

SIT meeting IEP ILP 504 or Accommodation Plan

Please include copies of any documents that the school has shared with you that contain the IEP, ILP, 504 or accommodation plan for Dr. O'Hagan to review. If you do not have copies of these forms, please try to get them from your child's school.

Please circle all direct services you child has received at school since last seen (outside main classroom instruction).

Reading Math Writing Other Motor Skills Speech Social Skills Groups

Other (please describe)_____

Please circle any of the accommodations that your child has received at school since last seen.

Extra time Testing in a separate setting Oral Testing Copies of Notes Spelling

Reduced or shortened assignments Allowed Calculator Allowed multiplication Chart

Foreign Language Waived

Other: _____

Please summarize or list the current reasons for this re-evaluation.

Please describe this child's strengths / areas that come easily to them.
*(this might include academic, social, personality, athletic, intellectual, or spiritual )*

Please describe this child's weaknesses / concerns you have about your child.

## HEALTH HISTORY

Current Health Providers

**Pediatrician**

Practice name _____

Health Provider who knows your child best: _____

Phone Number:_____

**Other relevant healthcare providers:**
(i.e. naturopath, allergist, eye doctor, audiologist, psychiatrist, therapist, speech therapist, occupational therapist, tutor, or any other specialist)

Provider name _____

Area of specialty/reason seen: _____

Phone Number:_____

Provider name _____

Area of specialty/reason seen: _____

Phone Number:_____

Provider name _____

Area of specialty/reason seen: _____

Phone Number:_____

Provider name _____

Area of specialty/reason seen: _____

Phone Number:_____

## HEALTH HISTORY

Please fill out this form as completely as possible. Please include any health related issues that have occurred since last seen.

Please list any **serious illnesses** this child has experienced, age and describe as appropriate.

| Type of Illness | Age | Description/ Treatment |
|---|---|---|
| | | |

Please list any **serious accidents** this child has had.

| Type of accident/injuries incurred | Age | Description/Treatment |
|---|---|---|
| | | |

Please list **any hospitalizations** this child has had.

| Reason for hospitalization | Age | Description |
|---|---|---|
| | | |

Does this child have a **history of ear infections**? Yes (describe below) No

| Any specific cause / type | Age(s) | Duration | Treatment |
|---|---|---|---|
| | | | |

Does this child have **a history of seizures or convulsions**? Yes (describe below) No

| Cause (if known) | Age(s) | Duration | Treatment |
|---|---|---|---|
| | | | |

Does this child have **allergies**? Yes (describe below) No

| If yes – please list allergens, any medications / treatment, how well managed they are, whether injections have/are received and whether this interferes with any activities, including sleeping. |
|---|
| |

Does this child have **asthma**? Yes (describe below) No

| |
|---|
| If yes – please describe when worse (i.e. triggers), any medications / treatment, how well controlled it is and whether this interferes with any activities, including sleeping. |

Does this child have frequent **headaches, stomach-aches and/or vomiting**? Yes (describe below) No

| |
|---|
| If yes – please describe any known causes or patterns to these occurring (summer vs. school year, time of day, day of the week) and how treated. |

Please list any other diagnosed **physical or mental health problems or genetic conditions**.

| Type of Illness/Condition | Age | Description/ Treatment |
|---|---|---|
| | | |

**CURRENT medications** (prescription and over-the-counter): Please list

| Name of medication | Dosage | Reason for medication |
|---|---|---|
| | | |

**CURRENT supplements or vitamins**: Please list

| Name of supplement | Dosage | Reason for supplement |
|---|---|---|
| | | |

Any hearing issues?

| |
|---|
| Date of **most recent hearing check** (month/year):<br><br>Completed by / at:<br><br>Was this a test with headphones or a "booth test" (circle one)<br><br>Outcome/recommendations: |

Any vision issues?

Has vision therapy ever been recommended or received? Yes (please describe) No

Does this child wear contacts or glasses? Yes No
(If yes – please make sure these are brought to the assessment)

Date of **most recent vision check** (month/year):

Completed by / at:

Was the evaluator an optometrist (O.D.) or an ophthalmologist (M.D. (circle one)

Outcome/recommendations:

Since last seen:

Has this child had **a speech evaluation or received speech therapy?** Yes (please describe) No

| Name (s) of therapist (s) / Agency | Dates/Age/Grade seen | Focus of treatment (articulation, broader language) |
|---|---|---|
| | | |

Has this child had an **OT evaluation or been seen by an OT** ? Yes (please describe) No

| Name (s) of therapist(s) ? Agency | Dates / Age / Grade seen | Focus of treatment (gross, fine, sensory) |
|---|---|---|
| | | |

Has this child had a **private educational, or psychologist evaluation**? Yes (please describe) No

| Name of examiner / Agency | Date / Age / Grade | Focus / reason for evaluation / Any diagnoses made |
|---|---|---|
| | | |

Since last seen:

Has this child been followed by a **psychiatrist**? Yes (please describe) No

| Name of psychiatrist | Date / Age / Grade | Focus / reason for consultation / Any diagnoses made / any treatment prescribed |
|---|---|---|
| | | |

Has this child received **tutoring**? Yes (please describe) No

| Name(s) of tutor(s) | Dates / age / grade | focus of tutoring |
|---|---|---|
| | | |

Has this child received **counseling** (individual, group or family)? Yes (please describe) No

| Name(s) of therapist(s) | Dates / age / grade | Focus of therapy |
|---|---|---|
| | | |

Please list your child's involvement in any extra-curricular activities (include sports, dance, clubs, structured activities). Please include the time commitment for each (i.e. weekly, 5 days/week, only in spring, etc).

If relevant, please describe any family circumstances or life events occurring since they were last seen that you feel may be relevant to understanding this child. This could include changes in residence or jobs, family conflict, job loss, deaths or illness of family or friends, etc.

List anyone in immediate or extended family who has had difficulties in school (trouble learning to read, etc), dropped out, or 'underachieved' OR has been formally diagnosed with a learning disability, ADD or AD/HD.

| **Person (relation to child)**<br>(Parents, grandparents, siblings, cousins) | **Learning Difficulty**<br>(reading, writing, math, foreign languages, etc.) |
|---|---|
| | |
| | |
| | |
| | |
| | |

List anyone in the immediate or extended family who has had behavioral, emotional, or substance use issues.

| **Person (relation to child)** | **Behavioral or emotional difficulty**<br>(overactive, anxious, depressed, legal problems, substance use) |
|---|---|
| | |
| | |
| | |
| | |
| | |

Please list any health problems experienced by immediate or extended family (neurological, immunological, diabetes, pulmonary, respiratory, or any other health problems):

| **Person (relation to child)** | **Health Difficulty** |
|---|---|
| | |
| | |
| | |
| | |

Finally, please **gather the following documents** and either (1) email them, (2) mail them back with the history form, (3) drop them off at my office, or (4) bring to the intake session. If it is easiest to give me the originals (especially in relation to longer documents like IEPs) that is fine.

If you drop them off and the suite door is open, please leave them on the counter to your right by the sink; if the door is locked, please put them in the mail slot in the door. Please email or text me when you drop them off so I know they are there. If you share originals, I will be sure to give them back to you after the assessment is completed.

**Please include any of the following documents if they apply:**

1. Copies of any assessments completed since last seen (**any** assessments: educational, psychological, speech, OT, vision, hearing, etc.)

2. Standardized test scores received since last seen (ITBS, Terra Nova, ERB, Plan, Explore, PSAT, ACT. SAT, etc.)

3. Any school-based benchmark testing that has been shared with you since last seen (usually in reading or math)

4. Report cards

5. Official school documents (previous and current accommodation plan, 504, IEP, etc.)

6. Anything else you think is helpful for understanding your child.