Language, Learning, and Speech Center of San Luis Obispo
1130 Grove Street
SAN LUIS OBISPO, CA 93401
(805) 543-3945

Name:_____ Male Female
Birthdate:_____ Name of School _____
Date of Evaluation: _____
Age: _____
Grade: _____
Parents: _____ _____
Address: _____ _____
_____ _____
_____ _____
Phone: _____
Currently living with _____. There are _____children in the family.
This child is number _____.
This child is ___ is not ____ adopted.

PRENATAL HISTORY
At what month was prenatal care sought? _____
Other than vitamins, were medications prescribed? _____
Was this a normal pregnancy? _____
Complications? _____
Were non-prescribed drugs used during pregnancy? _____ Alcohol? _____

LABOR AND DELIVERY
Child was born at hospital or at home?_____
Head or breech presentation? _____
Forceps delivery? _____
Any difficulty breathing at birth? _____
Was oxygen used? _____
Trouble with Rh factor? _____
Baby's birth weight? _____
APGAR score _____
How long did the baby stay in the hospital? _____

FEEDING
Does your child have any known food allergies? _____
As an infant was this child colicky? _____
Does this child need to eat frequently? _____
How much milk is consumed daily? _____
What behaviors are manifested when this child is hungry?
_____ _____

SLEEPING
When did this child first sleep through the night/? _____
What time is bedtime? _____ What time is a normal wake-up time? _____
Does your child do his/her best work in the morning or afternoon? _____
Is sleep restless? _____ Excessive? _____ Too little? _____

CHILDHOOD ILLNESSES
Ear infections _____
How often? _____
How many since birth? _____
Are the infections seasonal? _____
What medications are effective? _____
Side effects? _____

Asthma ? _____
Allergies? _____
Diarrhea with dehydration ? _____
Eye Problems? _____
Glasses? _____ Since the age of _____.
Seizures or epilepsy? _____
"Space out?" _____
Unexplained high fever? _____
Heart disease? _____
Diabetes?_____
Measles _____ Mumps _____
Scarlet Fever? _____ Meningitis _____
Fractures?_____
Hospitalizations? _____
Concussion requiring medical attention? _____ Age _____
Describe event. _____
Falls or Head Injury not requiring medical attention? _____ Age ___
Describe event. _____

DEVELOPMENTAL MILESTONES (Give approximate age)
Crawled at _____ First words at _____
Walked at _____Put 3-4 words together at _____
Bladder control at _____
Bowel control at _____
Don't know exactly but seemed to be: (circle)
lagging behind, about the same time, ahead of other children his/her age.

EDUCATIONAL HISTORY
Began childcare at the age of _____.
Began preschool at the age of _____.
Began kindergarten at the age of _____.
Describe Kindergarten experience, i.e. positive, crying, clinging....
_____.
Began first grade at _____.
Describe successes or frustrations in first grade.
_____
Began to have difficulty with concentration and attention at the age of _____.
Began to have difficulty with reading and spelling at the age of _____.
Describe your child's feelings about drawing, cutting, and coloring.
_____

How well does your child get along with same aged peers? _____
Younger children? _____ Older children? _____
Does he/she seem to prefer one type of friend? _____

How well does your child get along with his/her teachers? _____
What is your major educational concern? _____

_____

_____

What steps have you taken to assist your child?
i.e. Educational Child Psychologist, counseling, Student Study Team,
IEP, Tri-Counties Regional Center,, SELPA? ....
_____

_____

What do you want us to help your child with? What are your goals?

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____