

The Network for Behavior Change, pc

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There are no obstacles, only hurdles of varying heights. None is so great that it cannot be overcome, gotten around or gone under. Even mountains disintegrate with time.

REPORT OF: Information Questionnaire for Life-Domain Psychological Evaluation

Identifying Information

Date: _____

NAME: _____

First Contact: _____

MA#: _____ SS#: _____ - _____ - _____

Birthdate: _____

Current Address: _____

Current School: _____

Grade: _____

Current Custody of Child: _____ Copy of Record if Court Ordered

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Gender: _____ Race: _____ Chronological Age: _____

Reason for Referral

A. Describe medical necessity for services [i.e. to prevent child from being placed outside the home]

B. Identify additional purposes [i.e. respond to crisis situations]

Qualitative Observations

Hair color: _____ Eye color: _____ Stature: tall for age short for age average for age
 Right handed left handed ambidextrous Weight: overweight underweight average for age

Assessment Techniques Used (check item(s) used in this evaluation)

- Information Questionnaire (this form) and interview with parents, review of records
- Other assessment methods (specify)

Interview with education placement staff Other (specify): _____

Current Strengths (list all exceptional physical, mental or emotional skills or abilities, including favorite sport(s), favorite school subject(s), anything he/she does often is probably a strength)

Motivation for services (Does the child and the parent **want** to receive the services?) yes

Child's Name:

Date:

Needs and Concerns

Nature of concerns (*operational definitions*) *Ensure you discuss how the child expresses the behavior, either externally, internally or both and what it looks like.*

1. Target1 (specific target behavior):

2. Target2 (specific target behavior):

3. Target3 (specific target behavior):

Summary of family resources, strengths and barriers to treatment (*attachment patterns, influence of parental experiences on parenting skills*)

- A. Family composition, including relevant extended family (Identify each biological parent, household member, step-parent, sibling/half-sibling, etc.)

- B. Marital status of parents

- C. Nature of child's contact with a non-custodial parent

- D. Family ethnicity

- E. Family cultural/religious beliefs

- F. Family history of psychiatric disorder and any related treatment

Community resources, neighborhood safety issues, peer group, cultural and related issues (*including SSI, SSDI, Family Driven Waiver services, other assistance received by the family from friends, relatives, etc. Does the child participate in YMCA, church youth group, community sports or other organized activities? Is the neighborhood considered safe? Are there any cautions about travel in the neighborhood?*)

- A. Community attachments and activities (church group, Little League, etc)

- B. Patterns of peer relationships in the neighborhood

- C. Predominant age of peers (same-aged, older or younger?)

Child's Name:

Date:

D. Predominant gender of peer relationships:

E. Apparent or disclosed nature of neighborhood safety

F. Other team members, including involved professional agencies/systems (eg. MH/MR, C&Y, juvenile justice, case management, child psychiatrist, special education, etc.)

Psychological-Psychiatric History

A. History of child's initial behavior symptoms or classification with Serious Emotional Disturbance (SED)

B. Outpatient or Family Counseling (Reason, level of participation & effectiveness)

C. Partial Hospitalization (Reason, level of participation & effectiveness)

D. Out-of-Home Placement (Inpatient or Residential treatment, Reason, level of participation & effectiveness)

E. Witness to domestic or other violence?

F. Multiple separations from primary caregivers (especially for adopted children)

G. Victimization (*bullying, sexual molestation or exploitation*)

Educational History & School Behavior Concerns (*achievement including typical grades, classroom behavior, accommodations used by school, peer relationships, and apparent or existing Special Ed status*)

A. Academic adaptation (*How are the child's grades?*)

B. Characteristics of current school and specific class setting

C. Behavioral adaptation (*Are behavioral problems occurring at school? [describe]*)

Child's Name:

Date:

- D. Peer relationships at school (*victim of bullying, avoidant, friends?*)
- E. Relationships with teachers (*i.e. confrontational or friendly?*)
- F. Efforts of school to address current problems (*i.e. Do they have a Behavior Support Plan & do they use it?*)
- G. Characteristics of current class setting (*Ratio of students to teachers, total number of people in the class*)
- H. Current or past use of school-based services, if relevant (*i.e. Learning or Emotional Support, School Psychiatrist or Psychologist, OT, PT, Speech Therapy*)
- I. Prior school (*What other schools, pre-schools or daycares has the child attended? Provide timelines*)

Aggression & Suicidality History (*suicidal behavior, ideation, and history of aggression, if any*)

Maturation History (*developmental milestones including walking talking, gross-motor and fine-motor development, toilet training, cognitive development, peer relationships, interests, hobbies and talents, and general physical fitness*)

Dietary concerns, eating habits, food texture sensitivities:

Legal History (*legal circumstances relevant to treatment for both child and guardians*)

Substance Abuse History (*including eating or mouthing of inedible objects*)

Domestic Violence History (*note if this has been or is an issue and supply details if so*)

Medical Intervention History

- A. Developmental history **pregnancy:** (*including medical or psychological complications, maternal smoking and maternal drug or alcohol use. Also, prenatal care*)
- B. Developmental **milestones** (*motor, speech and language, cognitive, emotional, adaptive, as well as relational capacity*)

Child's Name: _____

Date: _____

Current medical status (*ongoing serious illnesses, other current medical concerns*)

- A. Medical illness, including acute & chronic infection (Lyme Disease, etc):

- B. Physical or sensory limitations:

- C. Serious injury, especially Brain injury (*Neurological disorder, seizures, loss of consciousness*)

- D. Lead or other toxicity:

- E. Last Physical Exam Date: _____

- F. Primary Care Physician Name, Address & Phone _____

Psychotropic Medication History, including indications and dosages received

Medication Name	Daily Dose	Prescribing Physician	Reason Prescribed & Start Date (Stop Date, if applicable)

- A. Psychiatrist Name, Address & Phone _____

- Occupational Therapy (Reason, schedule of sessions & effectiveness)

- Physical Therapy (Reason, schedule of sessions & effectiveness)

- Speech Therapy (Reason, schedule of sessions & effectiveness)

- Other therapy (Reason, schedule of sessions & effectiveness)

Noteworthy Effective Interventions (*identify the interventions that work well*)

Noteworthy Ineffective Interventions (*identify the interventions that have failed*)

Known barriers to Treatment (*any circumstances that could impede progress such as divorce, custody issues, parental refusal to engage in services, moving, etc.*)

Child's Name: _____

Date: _____

Mental Status Evaluation (Identify participants): _____

Hygiene and self-care: *Are there hygiene deficits? Does the child care for dressing, bathing or other activities of daily living **independently**?*

Judgment & Insight: *Does the child know right from wrong? Is he/she self-protective & avoids danger? Does the child have any idea of his/her situation and how it came about?*

Thought & Orientation: *Does the child see or hear things that "aren't there?" Does the child believe he/she has powers and abilities that are "beyond those of mortal men?" Are memory problems apparent? Does the child know the month, day, year and time? Does he/she know **where** he/she is and **who** he/she is?*

Mood: *Does the child's mood rise and fall in extremes? Is he/she prone to depression? Is the child now (or has ever been) suicidal or homicidal?*

Affect: *What is the child's typical emotional state (happy, depressed, suspicious, etc)?*

Suicidal and Homicidal ideation: *Is the child now (or has ever been) suicidal or homicidal?*

Impulse Control: *Can the child control impulses and tolerate delay in gratification?*

Psychosocial skills: *Can the child interact cooperatively with peers, or adults, or neither, or both?*

Physiological functions: *Any physical problem that influences behavior (such as seizures)?*

Perceptual: *Is there anything wrong with the child's senses (hearing, vision, smell, touch, taste)?*

Cognitive: *Is there any evidence of mental retardation (IQ < 72, poor social skills, age < 18)?*

Gender Preference for therapist expressed by child by parent No preference Male Female

Racial Preference for caregiver expressed by child by parent No preference Race: _____

Prognosis with treatment: good guarded poor

Child's Name: _____

Date: _____

DSM IV diagnoses

AXIS I:

AXIS II:

AXIS III:

AXIS IV:

AXIS V: Past: _____ Now: _____

Recommendations

Non-BHRS Recommendations (*Psychotropic medication referral, additional assessments, community referrals, education/vocation recommendations, consultation with primary care physician, etc*)

Therapeutic Staff Support Services:

School-Related (*times of day and days of the week that services are to be requested*):

	M	T	W	R	F	SA	SU	
FROM - TO								TOTAL
HOURS								

Home & Community (*times of day and days of the week that services are to be requested*):

	M	T	W	R	F	SA	SU	
FROM - TO								TOTAL
HOURS								

Mobile Therapist Services: _____ hours per week

Behavior Specialist Consultant: _____ hours per week

OTHER: