

List all people living in the household:

Name

Age

Education

1

Family Health

A large majority of learning issues and emotional disturbances are hereditarily based. Have any family members had any of the following? If yes, please specify family member's relationship to this child. If child is not living with biological parents, please include health information on biological parents if known.

1

- | | |
|--------------------------------------|----------------------------------|
| Alzheimer's disease _____ | Anemia _____ |
| Or Dementia _____ | Low or overactive Thyroid _____ |
| Pituitary Gland dysfunction _____ | Down's Syndrome _____ |
| Fragile X Chromosome _____ | Double YY Chromosome _____ |
| Cancer _____ | Tourette's Disorder _____ |
| Cystic Fibrosis _____ | Asperger's Syndrome _____ |
| Diabetes _____ | Neurofibromatosis _____ |
| Hypoglycemia _____ | Alcohol/drug abuse _____ |
| Heart disease _____ | Panic Attacks _____ |
| High blood pressure _____ | Atmospheric Allergies _____ |
| Kidney disease _____ | Emotional disturbance _____ |
| Migraine headaches _____ | Attention Deficit Disorder _____ |
| Multiple sclerosis _____ | Depression _____ |
| Muscular dystrophy _____ | Speech or language problem _____ |
| Parkinson's disease _____ | Food allergies _____ |
| Pervasive Development Disorder _____ | Nervousness/ Anxiety _____ |
| Stroke _____ | Seizures or epilepsy _____ |

1

Mental Illness (e.g. Bipolar Disorder, Manic Depression, Mania, Schizophrenia, Obsessive Compulsive Disorder) _____

Other: Describe _____

- Learning Problems-
- | |
|-------------------------------|
| Reading of Words _____ |
| Reading Comprehension _____ |
| Spelling _____ |
| Math Computation _____ |
| Math Concepts _____ |
| Handwriting _____ |
| Written Expression _____ |
| Oral Expression _____ |
| Listening Comprehension _____ |

Has anyone in the family ever been identified for special education services ? No Yes
 If yes, who? _____ What type of class? _____

Personality and Temperament

2

How would you describe your personality? _____

Choose those characteristics that apply to you

- | | | |
|---|---|--|
| <input type="checkbox"/> Lonely | <input type="checkbox"/> Acts young for age | <input type="checkbox"/> Flexible |
| <input type="checkbox"/> Dependable | <input type="checkbox"/> Acts old for age | <input type="checkbox"/> Bored |
| <input type="checkbox"/> Proper | <input type="checkbox"/> Easily influenced | <input type="checkbox"/> Hot Tempered |
| <input type="checkbox"/> Intelligent | <input type="checkbox"/> Enthusiastic | <input type="checkbox"/> Independent |
| <input type="checkbox"/> Daydreamy | <input type="checkbox"/> Prim | <input type="checkbox"/> Gets along well w/ others |
| | | |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Pessimistic | <input type="checkbox"/> Forgetful |
| <input type="checkbox"/> Messy | <input type="checkbox"/> Happy | <input type="checkbox"/> Even Tempered |
| <input type="checkbox"/> Resourceful | <input type="checkbox"/> Bully | <input type="checkbox"/> Detached |
| <input type="checkbox"/> Antisocial | <input type="checkbox"/> Victim | <input type="checkbox"/> Submissive |
| <input type="checkbox"/> Assertive | <input type="checkbox"/> Energetic | <input type="checkbox"/> Humorous |
| <input type="checkbox"/> Optimistic | <input type="checkbox"/> Shy | <input type="checkbox"/> Stubborn |
| <input type="checkbox"/> Rigid/Compulsive | <input type="checkbox"/> Fearful | <input type="checkbox"/> Compliant |
| <input type="checkbox"/> Confused | <input type="checkbox"/> Easily hurt feelings | <input type="checkbox"/> Resilient |
| <input type="checkbox"/> Unusual | <input type="checkbox"/> Neat | <input type="checkbox"/> Sensitive |
| <input type="checkbox"/> Friendly | <input type="checkbox"/> Underactive | <input type="checkbox"/> Scattered Attention |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Overactive | <input type="checkbox"/> Considerate |
| <input type="checkbox"/> Graceful | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Insecure |
| <input type="checkbox"/> Lazy | <input type="checkbox"/> Cries easily | <input type="checkbox"/> Secure |
| <input type="checkbox"/> Show-off | <input type="checkbox"/> Self-conscious | <input type="checkbox"/> Loving |
| <input type="checkbox"/> Obedient | <input type="checkbox"/> Likes to be alone | <input type="checkbox"/> Jealous |
| <input type="checkbox"/> Gentle | <input type="checkbox"/> Often sad | <input type="checkbox"/> Physical complainer |
| <input type="checkbox"/> Drowsy | <input type="checkbox"/> Helpful | <input type="checkbox"/> Clumsy |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Disobedient | <input type="checkbox"/> Dependent |
| <input type="checkbox"/> Different | <input type="checkbox"/> Fidgety | |

3

Birth

At birth, what was your mother's age? _____ Father's age? _____

2

Were you:

- | | |
|-------------------------------------|----------------------|
| <input type="checkbox"/> Premature: | How premature? _____ |
| <input type="checkbox"/> Late: | How late? _____ |
| <input type="checkbox"/> Full Term | |
| <input type="checkbox"/> Don't know | |

Length of labor: _____ Hours

Birth weight _____ lbs. _____ oz.

Child's condition at birth _____

Mother's condition at birth _____

Check any of the following complications that occurred during birth

3

- Breech birth Labor induced Vacuum Cesarean delivery
 Forceps – Position of forceps _____
 Other complications during delivery: Describe _____

Neonatal care: Explain _____

Incubator: How long? _____

Jaundiced: Bilirubin Count (Circle One) Very High, High, Just Above Normal
Bilirubin lights? Yes No How long _____

3

Breathing problems right after birth: Describe _____
Supplemental oxygen? Yes No How long _____

Child had illnesses and/or Diseases; Describe _____

Anesthesia used during delivery? Yes No What kind? _____

Length of stay in the hospital: Mother: _____ days Child: _____ days

If you did not come home from the hospital with the mother, why? _____

Development

At about what age did you do the following? *Please indicate approximate month and/or year of age*

1

_____ Sit alone _____ Show interest in or
_____ Crawl _____ attraction to sound

2

_____ Stand alone _____ Speak first words
_____ Walk alone _____ Speak in sentences

3

Did you experience any of the following problems? **If yes, please describe.**

- Chronic ear infections No Yes _____
 Age of onset _____ Frequency _____
 Antibiotic Type(s) _____ Dosage _____
 Tubes ? Yes No Still Occurring? Yes No

5

- Walking difficulty No Yes _____
- Too Sensitive to Touch No Yes _____
- Too Sensitive to Sound No Yes _____
- Unclear speech No Yes _____
- Eating problems No Yes _____
- Underweight problem No Yes _____
- Overweight problem No Yes _____
- Colic No Yes _____
- Sleep problems No Yes _____
- Difficulty learning to throw or catch No Yes _____
- Difficulty learning to kick or hit No Yes _____

During the first 4 years, were any special problems noted in the following areas?

If yes, please describe.

6

- Excessive Anger (Rage) No Yes _____
- Separating from parents. No Yes _____
- Excessive crying No Yes _____
- Nail biting No Yes _____
- Failure to thrive No Yes _____
- Masturbation No Yes _____
- Motor skills No Yes _____
- Head bumping or banging No Yes _____

Which hand do you use for writing or drawing? _____

For Eating _____ For Throwing, Catching, etc _____

During the Preschool/Kindergarten years:

How well did you cut?
 Poor Fair Good Excellent

How well did you glue?
 Poor Fair Good Excellent

How well did you color in the lines?
 Poor Fair Good Excellent

Later Development

From the age of 5 to the present time, were/are any special problems noted in the following areas?

If yes, please describe.

Difficulty learning to ride a bike	No	Yes	_____
Difficulty learning to skip	No	Yes	_____
Difficulty following directions	No	Yes	_____
Difficulty following multiple directions	No	Yes	_____
Difficulty articulating sounds, if so which sounds	No	Yes	_____
Difficulty discriminating words that sound similar	No	Yes	_____
Does/Did child often misspeak or substitute similar sounding words?	No	Yes	
Difficulty telling a story in sequence	No	Yes	_____

If a girl, when did you begin menstruation? _____

If a boy, when did you reach puberty? _____

At what age during adolescents did you begin to show signs of increased desire for independence? _____

Medical History

Have you had any of the following:

Serious accidents ___ No ___ Yes At what age? ___ Specify: _____
Serious illnesses ___ No ___ Yes At what age? ___ Specify: _____

Childhood Illnesses/Injuries

Please check the illnesses you have had and indicate age (year/month)

- | | |
|---|---|
| <input type="checkbox"/> Measles _____ | <input type="checkbox"/> Rheumatic fever _____ |
| <input type="checkbox"/> German Measles _____ | <input type="checkbox"/> Diphtheria _____ |
| <input type="checkbox"/> Mumps _____ | <input type="checkbox"/> Meningitis _____ |
| <input type="checkbox"/> Chicken pox _____ | <input type="checkbox"/> Encephalitis _____ |
| <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Anemia _____ |
| <input type="checkbox"/> Whooping Cough _____ | <input type="checkbox"/> Fever 104 or above _____ |
| <input type="checkbox"/> Scarlet Fever _____ | |
| <input type="checkbox"/> Head injury: Describe-occurrence and location on skull _____ | |
| <input type="checkbox"/> Coma or loss of consciousness: Describe _____ | |

Seizure(s) Check behaviors evident during and immediately following seizure (378)

- Muscle twitches
- Hallucinations of flashes of light
- Numbness or tingling reported in a specific body part
- Image Hallucinations and/or complicated repetitive behavior, e.g. walking in circles
- Chewing movements/ Lip smacking
- Intense smell reported (pleasant or unpleasant)

Have you ever been on long-term prescribed medication (more than 6 months)? No Yes
If yes, when? _____ What kind? _____

2

Have you ever taken medication for an Attention Deficit Disorder? No Yes
If yes, what medication? _____ Dosage? _____

Have you ever used any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Pep pills or uppers | <input type="checkbox"/> Tranquilizers or sedatives |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> LSD or other hallucinogens |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Narcotics |
| <input type="checkbox"/> Diet pills | <input type="checkbox"/> Other, specify _____ |
| <input type="checkbox"/> None | |

Do you or others think that you may have a problem with any of the substances listed above? No
Yes, specify substance _____

Are there any other factors, which could have caused insult to your central nervous system? _____

Please indicate whether you currently have any of the following problems. If yes, describe how often.

Frequent colds	No	Yes	_____
Chronic cough	No	Yes	_____
Asthma	No	Yes	_____
Hay fever	No	Yes	_____
Sinus condition	No	Yes	_____
Shortness of breath or dizziness			
With physical exertion	No	Yes	_____
Activity limitation due to:			
Heart condition	No	Yes	_____
Heart murmur	No	Yes	_____
Excessive vomiting	No	Yes	_____
Frequent diarrhea	No	Yes	_____
Constipation	No	Yes	_____
Stomach pain	No	Yes	_____
Nervous stomach	No	Yes	_____
Bingeing and purging	No	Yes	_____
Anorexia	No	Yes	_____

3

Urination in pants/bed	No	Yes	_____
Pain while urinating	No	Yes	_____
Excessive urination	No	Yes	_____

3

Muscle pain	No	Yes	_____
		When?	_____ Where? _____
Clumsy walk	No	Yes	_____
Poor posture	No	Yes	_____
Other muscle problems	No	Yes	_____

Frequent rashes No Yes _____
Bruises easily No Yes _____
Sores No Yes _____
Severe acne No Yes _____
Itchy skin (eczema) No Yes _____

Brain Damage from known trauma No Yes If yes, describe _____

Suspected Brain Trauma No Yes _____
Speech defects No Yes _____
Accident prone No Yes _____
Bites nails No Yes _____
Sucks thumb No Yes _____
Grinds teeth No Yes _____
Has tics/twitches No Yes _____
Bangs head No Yes _____
Rocks back and forth No Yes _____

Compulsive behaviors No Yes, describe _____

Nonverbal Learning Disorder No Yes _____
Sensory Integration Dysfunction No Yes _____
Other Neurological Condition No Yes _____

Allergy to medicine No Yes If yes, describe _____

Allergy to food No Yes If yes, describe _____

Other allergies No Yes If yes, describe _____

Ear infections No Yes _____
Hearing problems No Yes _____
Ear tubes No Yes _____
Date of most recent hearing exam _____

Vision problems No Yes _____
Wears glasses or contacts No Yes _____
Date of most recent eye exam _____

Medical Care

Your physician _____ Telephone _____
Address _____

How often do you see a doctor? _____ Date of last visit _____

Are you currently taking any medication? No Yes
If yes, indicate type and reason _____

3

3

Educational History

List schools you have attended

2	Grade School Name(s) _____
	City(s) _____
	Grade Level(s) _____
3	Middle School Name(s) _____
	City(s) _____
	Grade Level(s) _____
4	High School Name(s) _____
	City(s) _____
	Grade Level(s) _____
	Colleges _____
	Degrees _____
	GPA _____

Please indicate if you have had any of the following school experiences

Did you attend Kindergarten? No Yes
Any problems is Kindergarten? No Yes If yes, describe _____

Did you change schools for reasons other than normal academic progression? No Yes
If yes, explain _____

Were you retained a grade in school? No Yes If yes, when and why? _____

Did you skip a grade in school? No Yes If yes, when and why? _____

6	In grade school (K-5) did you have difficulty with reading? No Yes If yes, describe _____
---	--

In middle school (6-8) did you have difficulty with reading? No Yes
If yes, describe _____

In High School (9-12)? No Yes If yes, describe _____

In grade school (K-5) did you have difficulty with math? No Yes
If yes, describe _____

6

In middle school (6-8) did you have difficulty with math ? No Yes
If yes, describe _____

In high school (9-12) did you have difficulty with math? No Yes
If yes, describe _____

In grade school (K-5) did you have difficulty with written expression? No Yes
If yes, describe _____

In middle school (6-8) did you have difficulty with written expression? No Yes
If yes, describe _____

In high school (9-12) did you have difficulty with written expression? No Yes
If yes, describe _____

Did you get poor grades? No Yes

7

Have you ever been tested for special education services in the past. No Yes
When _____

8

Are you presently or did you ever receive some special education services or accommodations?

No Yes

If yes, describe _____

What areas did you have difficulty with in College? _____

9

Scores on the SAT (Verbal, Math and Combined) _____

Scores on any other Standardized Tests :

(Name of test and scores) _____

Primary difficulties on Standardized Exams (Comprehension, Working Within Time Constraints, Logical Reasoning, Written Expression, Mathematics, etc.)

BEHAVIOR SYMPTOMS OF LEARNING DIFFICULTIES FOR STUDENTS

Name: _____
DOB: _____

Date: _____
Age: _____

- ____ 1. Unhappiness with school
- ____ 2. Complains about teacher(s)
- ____ 3. Easily frustrated
- ____ 4. Anxious; or ____4a panics under pressure
- ____ 5. Reluctance to read
- ____ 6. Reluctance to sit and be read to
- ____ 7. Reluctance to study or ____7a do other sedentary tasks, e.g. _____
- ____ 8. Poor study skills
- ____ 9. Slow reading; or ____ poor reading
- ____ 10. Difficulty with sounding out words
- ____ 11. Is primarily a “sight reader”
- ____ 12. Adds words, leaves out words, or substitutes words
- ____ 13. Poor spelling; or ____13a does okay on spelling test but forgets words later
- ____ 14. Poor vocabulary
- ____ 15. Difficulty understanding what is read
- ____ 16. Difficulty remembering what was read
- ____ 17. Difficulty understanding what is heard
- ____ 18. Difficulty remembering what was heard
- ____ 19. Difficulty expressing thoughts ____19a verbally or ____19b in written form
- ____ 20. Learning a foreign language very difficult even after hard study
- ____ 21. Thinks concretely or literally; ____21a Can’t “read between the lines”
- ____ 22. Has difficulty foreseeing consequences
- ____ 23. Trouble telling time or difficulty with minutes, hours, months, etc.
- ____ 24. Difficulty understanding or telling jokes
- ____ 25. Words appear to move, jiggle or dance
- ____ 26. Skips line(s) when reading
- ____ 27. Sees flashes of light or blotches when viewing page or screen
- ____ 28. Words are blurry even though vision is okay or has corrective lenses
- ____ 29. Doesn’t see spaces or enough space between letters and/or words
- ____ 30. Poor memory for what words say (can’t recall what whole word says – not a “sight” reader) or seems to forget “the,” “and,” “when,” “went,” “there,” etc.
- ____ 31. Attempts to use phonetic spelling all of the time
- ____ 32. Cannot write letters of the alphabet or cannot do so without great difficulty
- ____ 33. Can’t keep columns straight in math
- ____ 34. Dislikes or hates math
- ____ 35. Trouble with times tables and basic math facts
- ____ 36. Can’t understand new math concepts
- ____ 37. Can’t remember combinations
- ____ 38. Distractible ____38a Hard to focus attention
- ____ 39. Difficulty in following directions
- ____ 40. Difficulty in getting work done; ____40a Difficulty following through
- ____ 41. When does homework, forgets to turn it in
- ____ 42. Disorganized and/or problems with sequencing and planning
- ____ 43. Inaccurate copying
- ____ 44. Sloppy or illegible writing
- ____ 45. One or more biological family members have problems in (circle appropriate one(s)): reading, spelling, writing, enjoying reading, passing a grade or class
- ____ 46. Has been held back or not passed a grade.
- ____ 47. Had speech and/or language therapy
- ____ 48. Is in or thought to need remedial reading (tutoring or class)
- ____ 49. Is in or thought to need a learning disability (L.D.) class

SSIS CHECKLIST

GENERAL CHARACTERISTICS:

- reads in dim light
- never feels lighting is just right
- bothered by glare
- light sensitive

APPEARANCE OF THE EYES:

- reddened eyes and lids
- watery eyes

COMPLAINTS:

- headaches
- burning or itching eyes

- sandy, scratchy, dry eyes
- falls asleep when reading

- words double, move or look fuzzy

- words are blurry or fuzzy
- words disappear

OBSERVATIONS WHILE READING:

- rubs eyes
- moves closer to or further from reading material
- excessive blinking
- squinting
- opens eyes wide
- shades page with hand or body

- must incorporate breaks into reading
- moves the book to reduce glare

- closes or covers one eye
- moves head (tracks)
- reads close to the page
- reads word by word
- uses fingers or other marker routinely
- unable to skim or speed read

TYPES OF READING DIFFICULTIES:

- skips words or lines
- cannot read for longer than one hour
- loses place
- reading is slow and hesitant
- omits small words
- deteriorate as reading continues

COMPLAINTS ON COMPUTERS:

- eye strain and fatigue
- headaches
- trouble reading across columns

WRITING:

- writes up or down hill
- unequal spacing between letters and words
- inability to write on the line
- makes errors copying from books or board
- squints or blinks while copying from board

MATHEMATICS:

- misaligns digits in number columns
- difficulty seeing numbers in the correct column
- sloppy, careless errors

MUSIC:

- plays by ear and has difficulty reading musical notes

DEPTH PERCEPTION:

- difficulty getting on and off escalators
- clumsy
- walks into table edges or door jambs
- difficulty judging distances

For information on an Initial Screening for Scotopic Sensitivity Syndrome and Irlen Lenses contact:
Denton Kurtz

Attention-Activity Questionnaire

Please circle any of the following of I, II or IM, that have persisted for at least six months and are considered maladaptive and inconsistent with the person's developmental level.

- I.
 - 1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
 - 2. Often has difficulty sustaining attention in tasks or play activities.
 - 3. Often does not seem to listen when spoken to directly.
 - 4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).
 - 5. Often has difficulty organizing tasks and activities.
 - 6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).
 - 7. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools).
 - 8. Is often easily distracted by extraneous stimuli.
 - 9. Is often forgetful in daily activities.¹

- II.
 - 1. Often fidgets with hands or feet or squirms in seat.
 - 2. Often leaves seat in classroom or in other situations in which remaining seated is expected.
 - 3. Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness).
 - 4. Often has difficulty playing or engaging in leisure activities quietly.
 - 5. Is often "on the go" or often acts as if "driven by a motor".
 - 6. Often talks excessively.

- IM.
 - 7. Often blurts out answers before questions have been completed.
 - 8. Often has difficulty awaiting turn.
 - 9. Often interrupts or intrudes on others (e.g., butts into conversations or games).²

1. Which of the above circled symptoms were present prior to age seven? (list by letter(s) and number (i.e., I. #3, II. #5, and IM. #9):

2. Indicate the setting(s) where there is some impairment from the symptoms noted above: (please circle) home, school, work, social group, play, organized sport, other (specify)

3. What clear evidence is there to demonstrate that there is significant impairment in social, academic, or occupational functioning?

4. Are there other possible reasons for the symptoms circled? Underline possible reason(s): e.g., depression, anxiety, manic-depression, loosely associated, post-traumatic stress, environmental factors such as loose or polar parenting styles, physical and/or sexual abuse, excessive guilt, fear from unknown sources, other

¹Diagnostic and Statistical Manual of Mental Disorders: DSM-IV, 4th edition, American Psychiatric Association, Washington, DC, 1994. ²Ibid.

Have you ever had psychological counseling and/or exam? No Yes

If yes, psychiatrist or psychologist's name _____

Address _____

Telephone _____

Type of counseling _____

When? _____

Have you ever had a neurological exam? No Yes

If yes, Neurologist's name _____

Address _____

Telephone _____

Date of exam _____

Reason for exam _____

Will you give us consent to speak with these practitioners and exchange information?

No Yes

Signature _____

Date _____