Burke Little & Associates, Inc.

THERAPEUTIC AND EDUCATIONAL CONSULTING

Adolescent Information Form

Today's Date_____

Person Completing Form_____

Name of Student_____

Name of Parents or Guardian_____

Mailing Address_____
(Street) (City) (State, Zip)

Home Telephone _____ Cell (Mom)_____

Cell (Dad)_____

Student's Date of Birth _____ Current Grade in School_____

Mother's e-mail address _____

Father's email address_____

Current School: _____

Address:_____

Year of High School Graduation:_____ Currently in Grade:_____

School Guidance Counselor_____

Academic Advisor (*if different)* _____

School Phone: (_____)_____ School Fax: (____)_____

List all previous schools attended and include grades:

_____ _____

_____ _____

_____ _____

Student lives with (Check all that apply): Check any that apply: ____ Child is Adopted

____ Father ____Stepfather ____Guardian ____Father is deceased ____Parents divorced

____Mother ____ Stepmother ____Mother is deceased ____Parents separated

____Other (Please specify) _____ ____Father remarried ____Mother remarried

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If married, how long have you been married?_____

If divorced, how long have you been divorced? _____

If divorced, who has physical custody? _____

Who has legal custody?_____
Father's occupation_____ Mother's occupation: _____

Business address _____
Business address _____
Telephone_____ Telephone _____

Educational Background

Mother Father
High School_____ _____
College _____ _____
Adv. Degrees _____ _____

Student History

Educational History

_____

_____

_____

_____

_____

REASON FOR REFERRAL

Please describe the type of services you are seeking. If applicable, please describe any problems your child is now having.

_____

_____

_____

_____

_____

Psychological and educational testing, speech testing, language testing, occupational therapy date/results/diagnoses

_____

_____

_____

_____

_____

Special Education:

Does your child have an IEP or 504?

_____

_____

Areas of qualification: reading, math, writing, language, speech, OT, behavior, attention, other?

_____

_____

Amount of time in separate setting?

_____

_____

Amount of time in inclusion?

_____

_____

Additional information:

Has your child been in any gifted or accelerated classes? Which grades and classes?

_____

_____

What is your child most interested in or their passions?

_____

_____

Does your child have chores at home? What and how often?

_____

_____

Has your child held a job outside the home? When and what kind of work?

_____

_____

Please indicate if your child is experiencing any of the following difficulties

_____School attention/concentration problems

_____Grades dropping or consistently low

_____Hyperactive, difficulty being still

_____Sadness or Depression

_____Generalized Anxiety (across many situations)

_____Specific Fears or Phobias (List)_____

_____Obsessive-Compulsive / Rigid behavior patterns

_____Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)

_____ Isolated socially from peers

_____Problems making or keeping friends

_____Problems with eating

_____Problems falling asleep

_____Problems sleeping through the night (middle of the night or early morning waking)

_____Trouble waking up

_____Fatigue/tiredness during the day

_____Nightmares

_____Noncompliant, purposely does not obey (not due to language or cognitive deficits)

_____Oppositional, defiant behavior

_____Problems controlling temper

_____Tantrums / "Meltdowns"

_____Problems with authority (breaking rules or laws)

_____Physically aggressive towards others (biting, pinching, scratching, kicking, fighting)

_____Verbally aggressive (name-calling, screaming, swearing, unkind comments)

_____Self-injurious / Self-harm behavior (head banging, scratching, biting, cutting self)

_____Wetting accidents (indicate day or night wetting):

_____Soiling accidents or other bowel problems (withholding, refusal, fear/anxiety)

_____History of abuse (emotional, physical, sexual)

_____Alcohol or drug use/abuse

_____Vocal or motor tics (e.g, grunts, squeals, eye blinks, throat clearing, grimacing, involuntary movements)

_____Sensory problems (over-reacts or under-reacts to lights, sounds, tastes, textures, smells)

_____Stress from conflict between parents

_____Stress due to family financial problems

Use of technology:

_____

_____

Use of social media:

_____

_____

Sexual issues:

_____

_____

Gender Issues:

_____

_____

Drugs (history, which ones, how often):

_____

_____

Legal Issues:

_____

_____

Other behavior problems:

_____

_____

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MEDICAL HISTORY

Name of Child's Primary Physician: _____

Physician's Address:_____

Physician's Phone: _____

List any other physicians or health professionals your child sees for services on a regular basis (Psychiatrists, Therapists, Occupational Therapists, Speech Pathologists, etc.)

_____

_____

_____

_____

_____

When was your child last seen by a physician?

Rate your child's overall health _____Excellent _____Good _____Fair _____Poor

Child's current height: _____ft, _____in. Weight_____

Does your child have any vision problems?_____

Date of last vision test and who performed (physician, optometrist, school)

Does your child have any hearing problems?_____

Date of last hearing test and who performed (physician, audiologist, school)_____

Is your child: _____right handed _____left handed _____does not favor one hand

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other medical conditions your child has had.

_____

_____

_____

_____

_____

_____

List any medications your child is currently taking, including over-the-counter drugs, vitamins, and other nutritional supplements (include dosages). Also list previous medications and dates if taken for an extended period of time.

_____
_____
_____
_____

_____

_____

Social and Educational History

Name of current teacher (s):_____

What concerns does your child's teacher have about him/her?_____

_____

What is your child's favorite subject?_____

What is your child's least favorite subject?_____

Has your child ever repeated a grade?_____

Has your child ever skipped a grade?_____

Has your child ever had tutoring?_____

When and with whom?_____

Has this child ever been in a Special Education Program?_____

How much of the school day?_____

What type of program? (LD, Gifted, EBD, ASD, etc.)_____

Child's attitude toward school:_____

_____

How does your child interact with peers and adults in social situations?_____

_____

Do you have concerns about your child's social skills or development?_____

_____

What is your child most interested in? _____

_____

List your child's extracurricular activities, including sports, clubs, hobbies, lessons, etc._____

_____

_____

Describe your child's strengths, positive qualities, and any special abilities or skills.

_____

_____

What do you see as the student's best qualities? _____

_____

_____

What are the student's greatest problems or handicaps? _____

_____

_____

Additional Comments_____

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Religious preference of Student (optional)_____

Referred by: _____

Additional Thoughts_____

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