



Child Name: _____ DOB: _____ Age: _____

Gender: _____ Grade: _____

Address: _____ Phone: _____

Parent/legal guardian: _____ Insurance Company: _____

Email: _____ Insurance ID #: _____

Referred by: _____

Preferred Office Location: _____ Arlington _____ Plano _____

Evaluation Concerns:

ADD/ADHD	Bipolar	Intellectual Disability
Anxiety	Depression	Mood Disorder
Autism	Developmental	Neurological Disorder
Other _____		

Has your child been evaluated or diagnosed before?

Yes Year Evaluated & Diagnosis _____ No

Is your child seeing a Psychiatrist & taking medication?

Yes Psychiatrist Name & Medication _____ No

Has your child ever been hospitalized? No

Yes Please provide reason for hospitalization, hospital name, year hospitalized, length of stay, and diagnosis given:

Has your child received any of the following treatment?

Counseling

Speech Therapy

ABA Therapy

School Accommodations

Occupational Therapy

Please check any of the following symptoms your child is experiencing:

Anxiety

Panic Attacks

Shutting Down

Overwhelmed Easily

Poor Eye Contact

Poor Social Skills

Speech Delay

Stimming

Sensory Sensitivity

Upset by Change in Routine

Developmental Delays

Bed Wetting

Food Hoarding

Nightmares

Self-Harm

Suicidal Thoughts

Suicidal Attempts

Anger

Tantrums/Outbursts

Defiant/Argumentative

Lying

Bullying Others

Being Bullied

Fire Setting

Stealing

Cruelty to Others

Cruelty to Animals

Destruction of Property

Depression

Mood Swings

Crying Spells

Lack of Interest

Lack of Motivation

Irritability

Aggression

Trouble Focusing/Paying Attention

Hyperactive

Disruptive in Class

Talking Too Much

Poor Grades

Previous Trauma

History of Abuse

History of Neglect

Trouble with Reading

Trouble with Math

Additional Concerns or Comments?

Thank you! A member of our Administrative team will reach out to you within 24-48 hours to schedule an appointment.
