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Testing Information Form – Child

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to your child or you are not comfortable answering them, leave them blank.

Today's date _____ parent/legal guardian e-mail _____

Who referred you? _____

Client's full name _____

Preferred name _____

Birth Sex: _____ Gender Identity: _____

Ethnic background _____ Cultural preference _____

Religious preference _____

Parent/legal guardian completing this form _____

Parent/legal guardian marital status _____

Residential Parent and Phone # (In cases of divorce) _____

Other parent phone # _____

Parenting Arrangements (In case of Divorce) _____

Parent/legal guardian Employment _____

Parent/legal guardian Employment _____

Was this child adopted? No _____ Yes _____ If so, please provide details of the adoption including age of child, reason for the adoption, country or origin, anything known about biological parent(s), etc.

FAMILY INFORMATION (Please list names of everyone who lives in the current household with the child)

Name	Age	Relationship to Client	Highest Grade of School Completed (or current grade)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Family Stressors (check any that apply):

- Family conflicts
- Parent/Child conflicts
- Financial problems
- Partner conflicts
- Recent deaths
- Physical illness (Medical problems)
- Frequent moves
- Drug/alcohol abuse by parents/family members
- Trauma
- Other _____

Why did you want the child to be evaluated? List the behaviors you want to change.

Briefly describe your relationship with your current support system and your child's support system:

HISTORY OF CURRENT PROBLEMS

The current problems developed when the child was approximately age _____

At that age, the following difficulties were noted (please list briefly):

Please indicate any events occurring around that time that you believe may be related to the problems noted above:

How many hours does your child sleep a day? _____

How much time per day does your child spend on social media? (e.g. Tic Tok, Instagram, Facebook, cell phone)

How many hours per day does your child play video games or watching TV? _____

How are your child's eating habits?

Substance use/abuse or suspected abuse (check all that apply):

- alcohol marijuana cocaine heroin/opiates
- tranquilizers hallucinogens, LSD PCP, "dust" "ecstasy"
- others: _____

Has the child experienced traumatic/threatening events or been exposed to stressful events?

Are there any problems not already mentioned?

PAST PSYCHIATRIC HISTORY OF CHILD

List other testing and approximate date(s) seen-please bring a copy to your first appointment:

MEDICAL HISTORY OF CHILD

Name of Primary Care Physician _____

Address _____

—

Telephone _____

—

When did the child most recently see their primary care physician?

Previous hospitalizations, surgery or major illnesses:

Dates of treatment/illness	Nature of medical problem	Outcome of condition/treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medications

Current Medication(s):

Dose Level of Medication(s):

Medication to which child is allergic:

Description of allergic reaction:

Other allergies (e.g., specific food allergies, ragweed, cats, etc.):

Child's Immunization History

Are required immunizations up to date? Yes No

DEVELOPMENTAL AND PERINATAL HISTORY: check here if unknown

of pregnancies prior to this child: _____

of live births prior to this child: _____

of miscarriages/stillbirths prior to this child: _____

Pregnancy check here if unknown

Y N

- Full term (=40 weeks)?
- Medications for the mother? If yes, specify: _____
- Bleeding/Spotting?
- Persistent vomiting?

Y N

- Eclampsia/pre-eclampsia, high blood pressure, swelling, urine protein?
- Gestational diabetes?
- Drugs or other toxic substances to which biological mother was exposed? _____
- Other illnesses?

Labor and Delivery check here if unknown

Y N

- Vaginal Delivery
- C-Section, emergency?
- C-section, planned?
- Forceps used?
- Meconium stain (feces in amniotic fluid)
- Breech presentation?
- Fetal bradycardia (slow heart rate)

Infant's condition at birth _____

Birthweight of child: _____pounds _____ounces

First Year of Life check here if unknown

Y N

- Eat well?
- Slept well?
- Fretful?
- Colicky?
- Did your child struggle against you—touching, holding, hugging, etc?
- Did your child avoid looking at you?
- Any major health issues during child's first year of life.

If yes, what were they _____

Milestones check here if unknown

Age at walking unassisted (motor development)

Age baby spoke first words (language development)

Age child started using full sentences _____

Age at which child started reading _____

Age at which child could use the toilet consistently _____

Social Development

Does your child play well with other children?
Describe _____

Does your child seem emotionally detached from other children/adults?

Special interests/hobbies _____
—

ACADEMIC HISTORY (Please list schools attended, beginning with the most recent)

Name of School(s)	Dates/grades attended
_____	_____
_____	_____
_____	_____
_____	_____

Retained in school
Grade Retained _____ Reason _____
List any difficulties at school:

Y N

Previous Psychological Assessments for Developmental or Learning Problems

Type _____

When _____
—

- Does your child use 504/IEP?
- Does your child receive special educational services? _____
- Does your child participate in gifted programs at school? _____

LEGAL HISTORY OF CHILD (Please describe any legal issues in which your child has been involved.)

FAMILY PSYCHIATRIC HISTORY

Please indicate the presence in biological relatives of any psychiatric problem, such as depression, suicide, alcoholism, drug abuse, anxiety, panic attacks, bipolar disorder, schizophrenia, intellectual disabilities, autism spectrum disorder, learning disability, attention deficit hyperactivity disorder, childhood behavior problems, school or academic problems, narcolepsy, obsessive compulsive disorder, etc.

Please provide details about problem(s) here:

Y N N/A

Child's father

Father's parents, brothers, sisters

Child's mother

Mother's parents, brothers, sisters

Child's brothers and sisters

Other biological relatives

Family Circumstances: Please provide any information about the family that you feel would be important to understand the child's development and current problems:
