

# Pre-Evaluation Questionnaire

Name of person evaluated: \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female  
Last First MI

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Father's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Home phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Home phone \_\_\_\_\_

Other/Guardian's Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to student \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_ E-mail address \_\_\_\_\_

## **General History**

Give a brief statement of the primary reason for today's evaluation: \_\_\_\_\_

Indicate any diagnosis/labels/disorders that have been used to describe this person:  ADD  ADHD  Dyslexia/Reading problem  
 Learning Disability  Autistic/Asperger's/PDD  Speech/Language Disability  Physical Disability  Other: \_\_\_\_\_

## **Academic History**

Indicate any problems in the following areas:

- |                                   |  |  |  |
|-----------------------------------|--|--|--|
| <input type="checkbox"/> Reading  | <input type="checkbox"/> Comprehension                 | <input type="checkbox"/> Reversals of letters or words | <input type="checkbox"/> Motivation/behavior |
| <input type="checkbox"/> Writing  | <input type="checkbox"/> Avoidance of schoolwork       | <input type="checkbox"/> Loses place/skips lines       | <input type="checkbox"/> Low self-esteem     |
| <input type="checkbox"/> Math     | <input type="checkbox"/> Works too hard on school work | <input type="checkbox"/> Poor memory                   | <input type="checkbox"/> Overly active       |
| <input type="checkbox"/> Spelling | <input type="checkbox"/> Slow work                     | <input type="checkbox"/> Attention/concentration       | <input type="checkbox"/> Other: _____        |

Is the student achieving at expected levels in school?  Yes  No (please describe): \_\_\_\_\_

Type of classroom:

- mainstream for all subjects
- special classroom for all subjects (please explain): \_\_\_\_\_
- special classroom for some subjects (please explain): \_\_\_\_\_

Is the student receiving any help outside of school for the above problems?  Yes  No

If yes, please explain: \_\_\_\_\_

Has the student ever repeated a grade?  Yes  No If yes, please explain: \_\_\_\_\_

## **Medical History**

Birth was:  premature?  on time?  late? Birth weight: \_\_\_\_\_

Were there any complications during pregnancy or delivery?  Yes  No If yes, please explain: \_\_\_\_\_

List all major health problems to date: \_\_\_\_\_

List all medications currently being taken: \_\_\_\_\_

List any allergies: \_\_\_\_\_

Indicate problem areas:  headaches  vision  speech or hearing (please explain): \_\_\_\_\_

Head or eye injury?  Yes  No If yes, please explain: \_\_\_\_\_

List any current or previous training: \_\_\_\_\_

Would you like a copy of the screening results sent to the student's teacher?  Yes  No Physician?  Yes  No

Teacher name and address: \_\_\_\_\_

Physician name and address: \_\_\_\_\_

Complete both sides

1