Lifescapes Counseling Associates, PLLC
950 Windy Rd, Suite 305
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What To Expect During Your Child's Evaluation

Taking your child to a mental health professional for an evaluation is a major decision for any parent. Many parents do not know what to expect from such an evaluation and they can do well to be prepared for it. We would like to help prepare you for your child's evaluation so that the time you spend with the professional can be used to its maximum advantage.

Getting Ready

In deciding to seek professional help, consider what your concerns are at the moment. Typically, these concerns reflect problems with your child's behavioral, emotional, family, school, or social adjustment. While waiting for your child's appointment date, take time to sit down with a sheet of paper to list concerns that you, your child's teachers, and other family members may have. Also give consideration to problems you think are occurring in your family besides those of your child. We will mail/email you a packet of questionnaires regarding your child's developmental and health history, as behavioral rating scales, to be completed before the evaluation date.

The Evaluation

The clinical interview with you, the parents, is probably the most important component of the comprehensive professional evaluation if your child or adolescent. Other important elements are your completed behavioral questionnaires about your child, an interview with your child's teachers, and similar behavior questionnaires about the child completed by his/her teachers.

Before professionals can identify or diagnose a child as having a behavioral, emotional, or learning problem, they must collect a great deal of information about the child and family, sift through the information looking for the presence of psychological disorders, determine how serious the problems are likely to be, rule out or rule in other disorders or problems the child might have, and consider what resources are available in your area to deal with these problems.

Once we receive the completed packet of questionnaires from you and your child's teacher, the evaluation session can be scheduled. During the first session, the child's parent(s) will be interviewed in-depth. This session will last 1-2 hours. During a subsequent session or sessions, testing will be completed with the child, and depending on the age of the child, they might be interviewed as well. This can be done in one long session, or if more appropriate for the child, two shorter sessions.

After the information has been synthesized, a written report will be completed. Parents will attend a feedback session in which the findings are explained, as well as any diagnoses and recommendations for treatment. If the child is old enough and wishes to attend, he or she may come as a part of this session as well. After this time, the written report will be released to you and you will have a chance to ask any questions that you may have.

General Instructions for Completing the Questionnaires

As part of processing your request for an evaluation of your child at our clinic, we must ask you to complete the enclosed forms about your child and your family. We greatly appreciate your willingness to complete these forms. Your answers will give us a much better understanding of your child's behavior at home and your family circumstances. In completing these forms, please follow these instructions as closely as possible:

ALL forms in this packet should be completed by the parent who has the primary responsibility of caring for the child. In cases where both parents reside with the child, this is to be the parent who spends the greatest amount of time with the child.

If a second parent wishes to complete a second packet of information about this child, he/she may do so independently by requesting a second set of these forms. He/she may call our administrative assistant, ____________________________, at _____________________ (phone) and the packet will be sent out promptly.

If your child is already taking medication for assistance with his/her behavior management (such as Ritalin) or for any emotional difficulties (such as an antidepressant), we will ask that you complete the questionnaires about your child's behavior based on how your child behaves when he/she is OFF this medication. It is very likely that you occasionally observe your child's behavior at periods when he/she is off the medication, and we want you to use those time periods to answer these questions about behavior. In this way, we can get a clearer idea of the true nature of your child's difficulties without the alterations produced by any medication treatments being used. However, some parents whose children have been on medication for a long time may not be able to give us this information. In this case, just complete the questionnaires based on your child's behavior, but check the third blank line below to let us know that you based your judgments on your child's behavior when he/she was on medication. Check one of the blanks below to let us know for certain on what basis you judged your child's behavior in answering our behavior questionnaires:

______ My child currently does NOT take any medication for behavior problems. My answers are based on my child's behavior while he/she is off medications.

______ My child is currently taking medication for behavior problems. However, my answers are based on my child's behavior while he/she is OFF the medication.

______ My child is currently taking medication for behavior problems. My answers are based on my child's behavior while he/she is ON medications.

Please list any medications your child is currently taking for behavioral or emotional difficulties:

____

Thank you for completing these forms and returning them promptly to us in the enclosed envelope.

PLEASE RETURN THIS FORM ALONG WITH THE COMPLETED QUESTIONNAIRES

CHILD AND FAMILY INFORMATION

Child's Name ________________________________ Birthdate________________ Age__________

Address ____
(Street) (City) (State) (Zip)

Home Phone ________________ Work Phone ________________ Cell ________________ Dad / Mom (Circle One)

Child's School __________________________________ Teacher's Name ________________________

School Address ____
(Street) (City) (State) (Zip)

School Phone ______________________________ Child's Grade ______________________________

Is child in special education? YES NO If yes, what type? __________________________________

Father's Name ________________________________ Age ____________ Education _____________

Father's Place of Employment ____

Type of Employment ____Annual Salary _____________

Mother's Name ________________________________ Age ____________ Education ______________

Mother's Place of Employment ____

Type of Employment ____Annual Salary ______________

Is the child adopted? YES NO If yes, age when adopted __________________________________

Are parents married? YES NO Separated? YES NO Divorced? YES NO

Child's Physician ____

Physician's Address ____
(Street) (City) (State) (Zip)

Physician's Telephone Number ____

Please list all other children in the family:

NAME	AGE	SCHOOL GRADE

DEVELOPMENTAL AND MEDICAL HISTORY

PREGNANCY & DELIVERY

Length of pregnancy (e.g. full term, 40 weeks, 32 weeks, etc.) _______________

Length of delivery (number of hours from initial labor pains to birth) _______________

Mother's age when child was born _______________

Child's birth weight _______________

Did any of the following conditions occur during pregnancy/delivery?

Condition		
Bleeding	YES	NO
Toxemia/Preeclampsia	YES	NO
Rh factor incompatibility	YES	NO
Frequent nausea or vomiting	YES	NO
Serious illness or injury	YES	NO
Took prescription medications	YES	NO
If yes, name of medication ___________________________		
Took illegal drugs	YES	NO
Smoked cigarettes	YES	NO
If yes, approximate number of cigarettes per day __________		
Used alcoholic beverages	YES	NO
If yes, approximate number of drinks per week ____________		
Was given medication to ease labor pains	YES	NO
If yes, name of medication ___________________________		
Delivery was induced	YES	NO
Forceps were used during delivery	YES	NO
Had a breech delivery	YES	NO
Had a cesarean section delivery	YES	NO
Other problems	YES	NO
If yes, please describe _____________________________ ____		

Did any of the following conditions affect your child during delivery or within the first few days after birth?

Injured during delivery	YES	NO
Cardiopulmonary distress during delivery	YES	NO
Delivered with cord around neck	YES	NO
Had trouble breathing following delivery	YES	NO
Needed oxygen	YES	NO
Was cyanotic, turned blue	YES	NO
Was jaundiced, turned yellow	YES	NO
Had an infection	YES	NO
Had seizures	YES	NO
Was given medications	YES	NO
Born with a congenital defect	YES	NO
Was in hospital more than 7 days	YES	NO

INFANT HEALTH AND TERMPERAMENT

During the first 12 months, was your child:

Difficult to feed	YES	NO
Difficult to get to sleep	YES	NO
Colicky	YES	NO
Difficult to put on a schedule	YES	NO
Alert	YES	NO
Cheerful	YES	NO
Affectionate	YES	NO
Sociable	YES	NO
Easy to comfort	YES	NO
Difficult to keep busy	YES	NO
Overactive, in constant motion	YES	NO
Very stubborn, challenging	YES	NO

EARLY DEVELOPMENTAL MILESTONES

At what age did your child first accomplish the following:

Sitting without help ________________

Crawling ________________

Walking alone, without assistance ________________

Using single words (e.g., “mama,” “dada,” “ball,” etc.) ________________

Putting two or more words together ________________

Bowel training, day and night ________________

Bladder training, day and night ________________

HEALTH HISTORY

Date of child’s last physical exam: ______________________________________

At any time, has your child had the following:

Asthma	NEVER	PAST	PRESENT
Allergies	NEVER	PAST	PRESENT
Diabetes, arthritis, or other chronic illness	NEVER	PAST	PRESENT
Epilepsy or seizure disorder	NEVER	PAST	PRESENT
Febrile seizures	NEVER	PAST	PRESENT
Chicken pox or other common childhood illnesses	NEVER	PAST	PRESENT
Heart or blood pressure problems	NEVER	PAST	PRESENT
High fever (over 103 °)	NEVER	PAST	PRESENT
Broken bones	NEVER	PAST	PRESENT
Severe cuts requiring stitches	NEVER	PAST	PRESENT
Head injury with loss of consciousness	NEVER	PAST	PRESENT
Lead poisoning	NEVER	PAST	PRESENT
Surgery	NEVER	PAST	PRESENT
Lengthy hospitalization	NEVER	PAST	PRESENT
Speech or language problems	NEVER	PAST	PRESENT

Chronic ear infections	NEVER	PAST	PRESENT
Hearing difficulties	NEVER	PAST	PRESENT
Eye or vision problems	NEVER	PAST	PRESENT
Fine motor/handwriting problems	NEVER	PAST	PRESENT
Gross motor difficulties, clumsiness	NEVER	PAST	PRESENT
Appetite problems (over-eating or under-eating)	NEVER	PAST	PRESENT
Sleep problems (falling asleep, staying asleep)	NEVER	PAST	PRESENT
Soiling problems	NEVER	PAST	PRESENT
Wetting problems	NEVER	PAST	PRESENT
Other health difficulties	NEVER	PAST	PRESENT

Please describe: ____

____

ADHD Rating Scale-IV: Home Version

Child's Name: ______________________________ Gender: M F Age: _____ Grade: ______

Completed by: ______________________________ Relationship to child: _________________

Date: ____________________ General time of day evaluated: __________________________

Time of last medication, if any: _________________

Please circle the number that best describes the average of this child's behavior during the corresponding daytime period that you evaluated him/her during the past week.

This form is normed by gender, age, and situation. Please answer to the best of your ability.

	Never/ Rarely	Sometimes	Often	Always
Fidgets with hands or feet, or squirms in seat	0	1	2	3
Leaves seat in room or in other situations when expected to remain seated	0	1	2	3
Runs or climbs excessively in situations when it is inappropriate	0	1	2	3
Has difficulty playing quietly or engaging in quiet-time activities	0	1	2	3
Is "on the go" or acts as if "driven by a motor"	0	1	2	3
Talks excessively (too much)	0	1	2	3
Blurts out answers before questions have been completed	0	1	2	3
Has difficulty waiting for own turn	0	1	2	3
Interrupts or intrudes on others	0	1	2	3
Fails to give close attention to details or makes careless mistakes (includes tasks at home or at school)	0	1	2	3
Has difficulty sustaining attention in tasks or play activities	0	1	2	3
Does not seem to listen when spoken to directly	0	1	2	3
Does not follow through on instructions (e.g., fails to finish homework or chores)	0	1	2	3
Has difficulty organizing tasks and activities	0	1	2	3
Avoids tasks that require continued mental effort (e.g., schoolwork, homework)	0	1	2	3
Loses things necessary for tasks or activities	0	1	2	3
Is easily distracted	0	1	2	3
Is forgetful in daily activities	0	1	2	3

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Behavior Rating Scales for your Psychological Evaluation

As part of your child's evaluation, we will need to gather information from you and your child's teacher. These forms are delivered via email and you will be able to complete them and return them online. Please complete the information below so that rating scales can be sent via email. *Completion of this form indicates your permission to have these rating scale links delivered via email.*

YOUR CHILD'S INFORMATION:

First & Last Name: ____

Date of Birth: ____

____

Parent

First Name: ____

Last Name: ____

Email: ____

Second Parent (optional)

First Name: ____

Last Name: ____

Email: ____

Teacher

First Name: ____

Last Name: ____

Email: ____

Second Teacher (optional)

First Name: ____

Last Name: ____

Email: ____