CASTILLO SUMI CONSULTING
CHILD INFORMATION

Today's Date:	**Form Completed By:**	
Referral Source: □ Email Advertisement □ Phonebook Advertisement □ Other Advertisement □ Doctor □ Friend/Relative □ Return visit □ Sign on building □ other		
Referral Name:		
Child's Information		
Child's Name:		
Address:		
City:	**State:**	**Zip Code:**
Date of Birth:	**Age:**	**Gender:** □ Male □ Female
Ethnicity:	**SSN:**	**Home Phone:**
Parent's Information		
Parents Marital Status: □ Married □ Single □ Divorced □ Widowed		
Father's Information		
Father's Name:		
Address:		
City:	**State:**	**Zip Code:**
Email:		
Home Phone:	**Work Phone:**	**Cell:**
Occupation:		
Company:		
Company Address:		
Date of Birth:	**SSN:**	**Ethnicity**
Mother's Information		
Mother's Name:		
Address:		
City:	**State:**	**Zip Code:**
Email:		
Home Phone:	**Work Phone:**	**Cell:**
Occupation:		
Company:		
Company Address:		
Date of Birth:	**SSN:**	**Ethnicity**

Child's Name: DOB:

Guarantor's Information		
Responsible Party/Guarantor Name:		
Driver's Lic State & #	**SSN:**	**Date of Birth**
Employer's Name:		
Employer's Address:		
Phone:	**Fax:**	
Insurance Information		
Insured Employer:		
Insurance Carrier:	**Relationship to child:**	
Group #	**Member #:**	
Emergency Contact Information		
Name of nearest relative:		
Relationship:		
Home Phone:	**Work Phone:**	**Cell:**
Pediatrician's name:		
Address:		
Phone:	**Fax:**	
Background Information		
Living Situation		
Primary language at home:	**Other language spoken at home:**	

List names of those who live at home	Age (optional)	Relation to Child

Child's Name:
DOB:

If there is a *secondary* home, please list who lives at that home		
Primary language at home:	**Other language spoken at home:**	
Name	**Age (optional)**	**Relation to Child**

Medical Information

Is child adopted:	□ Yes □ No	**If yes, medical info available:**	□ Yes □ No
Allergies:	□ Yes □ No	**If yes, list:**	
Medical condition:	□ Yes □ No	**If yes, list:**	
Surgeries:	□ Yes □ No	**If yes, list:**	
Seizures:	□ Yes □ No	**If yes, is it recurring:**	□ Yes □ No
Bumps to head requiring medical attention:	□ Yes □ No	**If yes, when:**	
Emergency room visits:	□ Yes □ No	**If yes, reason and when:**	
Hospitalizations (other than surgeries):	□ Yes □ No	**If yes, when:**	
Hearing Tested?	□ Yes □ No	**Vision Tested?**	□ Yes □ No

Developmental History

Complication with pregnancy:	□ Yes □ No	**Complication with birth:**	□ Yes □ No
Birth type:	□ Vaginal □ C-Section	**Birth to term:**	□ Yes □ No

At what age did you first begin to have concerns about your child's development?
What were your first concerns?
Were the first concerns indicated to you by someone else *(e.g., pediatrician, day care provider)?*

If so, by whom?	**What was their concern:**

Has your child exhibited any apparent loss in skills? □ Yes □ No

Motor Development *(indicate age in months)*

Age child sat independently:	**Age child crawled:**
Age child walked unassisted:	

Child's Name: DOB:

Language	
Does your child use age-appropriate language? □ Yes □ No	
Age child said meaningful words:	**First words:**
Age of meaningful two-word phrases (e.g., "Go car," "My cup")	
Age of using gesture	

Social Development	
Does your child have opportunities for social interactions? □ Yes □ No	
Does your child have friends? □ Yes □ No	**Quality:** □ Close □ Acquaintance □ School Only □ Conflictual

Trauma History			
Sexual Abuse	□ Yes □ No	**Physical Abuse**	□ Yes □ No
Witness violence	□ Yes □ No	**Neglect**	□ Yes □ No
Guns in the home	□ Yes □ No	**Other**	□ Yes □ No

Family History					
	No Information Available		No significant medical history		No significant mental health history
	Seizures		Anxiety		Depression
	Suicide		ADHD		Bipolar
	Substance abuse		Tics- Motor or Vocal		Psychosis
	Learning Disability		Other:		Other:

If your child is ***5 years old and under*** **OR is does not have age-appropriate language**, please complete the following section.

Language Development	
Can your child select a named item from a field of 2 or more items?	□ Yes □ No
Can your child point to named body parts?	□ Yes □ No
Can your child point to named colors?	□ Yes □ No
Can your child point to "big" vs "little?"	□ Yes □ No

Child's Name:
DOB:

Motor Skills

Motor Imitation

Can your child do simple motor movements such as clapping or waving?	□ Yes □ No
Can your child imitate actions using objects (e.g., if someone says "do this?")	□ Yes □ No
Can your child imitate finger-play actions with a song?	□ Yes □ No
Can your child imitate finger-play actions with a song within a group?	□ Yes □ No

Gross Motor Skills: *Mark the skills your child is able to do:*

	Throw a ball		Kick a ball		Bounce a ball
	Catch a ball		Roll a ball		Raise arms up
	Jump on one foot		Twirl arms		

Fine Motor Skills*: Mark the skills your child is able to do:*

	Scribble		String beads		Write letters
	Write words		Draw pictures		Use scissors
	Draw lines		Draw shapes		Itsy bitsy spider
	Write name				

Self-Help Skills

Does your child wash/dry hands independently?	□ Yes □ No
Is your child toilet trained?	□ Yes □ No
Can your child get dressed independently?	□ Yes □ No
List household tasks in which your child assists.	
How does your child respond to danger?	

Play/Social Skills

Does your child make eye contact with the following people?

Father	□ Yes □ No
Mother	□ Yes □ No
Siblings	□ Yes □ No
Familiar People	□ Yes □ No
Others	□ Yes □ No

Does your child use toys in an unusual manner *(e.g., rubbing items against lips, tasting, spinning?)* □ Yes □ No

Child's Name: DOB:

Academic Skills					
	Recites alphabet		Labels letters		Reads words
	Stacks blocks		Points to named letters		Points to named numbers
	Labels numbers (up to what number? _____)		Can count to what number? _____		Counts with one-to-one correspondence
	Completes puzzle (What type? _____)				

This section should be completed for all children.

Service/Treatment History			
Psychiatric Treatment			
Did your child receive any clinical services in the past?	☐ Yes- If yes, complete the info below ☐ No- Skip this section		
Was your child prescribed medication in the past?	☐ Yes- If yes, complete the info below ☐ No		
Medication	**Purpose**	**Dosage**	**Prescribing Doctor**

Other Services				
If your child has received additional services in the past, please provide the information below				
Service	***Provider***	***Start Date***	***Frequency***	***Duration***
OT				
PT				
Speech				
Individual Therapy				
Group Therapy				
Family Therapy				
Substance Abuse				
Other:				

Child's Name:
DOB:

Current Status

Behaviors: *Does your child exhibit the following behaviors?*

Repetitive Behaviors:	□ Yes □ No	**Physical Aggression:**	□ Yes □ No
Social Withdrawal:	□ Yes □ No	**Property Destruction:**	□ Yes □ No
Ritualistic Behaviors:	□ Yes □ No	**Self-Injurious Behaviors:**	□ Yes □ No
Self-Stimulatory Behaviors	□ Yes □ No	**Unsafe/Dangerous Behaviors:**	□ Yes □ No
Substance Use	□ Yes □ No	**Sexual Activity**	□ Yes □ No

Current Service/Treatment

Psychiatric Treatment

Is your child currently receiving clinical services?	□ Yes- If yes, complete the info below	□ No- Skip this section
Is your child currently taking psychiatric medication?	□ Yes- If yes, complete the info below	□ No- Skip this section
Is your child currently taking non-psychiatric medication?	□ Yes- If yes, complete the info below	□ No- Skip this section

Medication	Purpose	Dosage	Prescribing Doctor

Other Services

If your child is currently receiving additional services, please provide the information below

Service	*Provider*	*Start Date*	*Frequency*	*Duration*
OT				
PT				
Speech				
Individual Therapy				
Group Therapy				
Family Therapy				
Substance Abuse				
Other:				

Child's Name:
DOB:

School Information		
Current School:		
Type of Placement: ☐ Regular Classes ☐ Special Education Classes ☐ Alternative School		
Does your child have a current IEP or 504 Plan? ☐ Yes ☐ No		
If yes, check services: ☐ Out of class resource ☐ OT ☐ Speech ☐ In-class resource ☐ PT ☐ Social Skills ☐ Other:		
List other school(s) and grade your child has attended in the past		
School	**Grade**	**IEP?** *Y or N*

Child's Preferences
Identify items that your child enjoys:
Food
Toys
Social Reinforcers (e.g., hugs, high five):
Physical activities
How do you believe your child learns best?
Does your child do tasks for the pleasure of completing the task and being recognized for having finished? ☐ Yes ☐ No

Desired Goals
What skills are priorities for your child (e.g., language, socialization)?
Short-term goals for your child?
Long-term goals for your child?

Thank you for taking the time to answer these questions!