Campagnoni ~ Hartlen & Associates
Psychologists

Developmental and Medical History for Psycho-Educational Assessment

****PLEASE BRING TO APPOINTMENT, AS WELL AS REPORT CARDS & OTHER DOCUMENTATION****

Feel Free to use the back pages if required

Child/Teen: _____

DOB: _____

Age: _____

Parents: _____

Address: _____

School: _____

Grade/Program: _____

Referral Source: _____

Assessment Date(s): _____

Please describe why your child is being assessed:

_____

_____

_____

_____

_____

Child lives with (please describe who lives in the home including siblings, step-siblings, etc.):

_____

_____

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PREGNANCY and DELIVERY – Any problems? No _____ Yes _____ Birthweight:_____

If problems, please explain when and what:

_____

_____

_____

_____

_____

Developmental Milestones:

	AGE	EARLY/ NORMAL/ LATE (Please Circle):		
Sat without help	_____	**E**	**N**	**L**
Crawled	_____	**E**	**N**	**L**
Walked without help	_____	**E**	**N**	**L**
Ride bicycle	_____	**E**	**N**	**L**
First word	_____	**E**	**N**	**L**
First phrases	_____	**E**	**N**	**L**
Simple sentences	_____	**E**	**N**	**L**
Began to read	_____	**E**	**N**	**L**
Learned bowel control	_____	**E**	**N**	**L**
Learned bladder control	_____	**E**	**N**	**L**
Stopped bedwetting	_____	**E**	**N**	**L**

Please indicate whether your child has any previous diagnoses including Learning, Medical, and/or Mental Health Disorders (e.g., Learning or Intellectual Disability, ADHD, Anxiety, Depression, Autism, Diabetes, Thyroid, etc.)

_____

_____

_____

_____

Does your child take any medications? If yes, please name type and reason:

_____

Please provide any family history of learning, medical or mental health disorders:

_____

_____

_____

Has your child been hospitalized, had any major illnesses or accidents? If yes, please explain:

Last Vision Test and Results:

Last Hearing Test and Results:

Do you have any concerns about your child's sleep habits (e.g., going to bed, falling asleep or waking through the night, etc.)?

Has your child experienced any major stressors recently or throughout their lifetime (e.g., conflicts, death, illness, divorce)? If yes, please explain when and what:

Have any other specialists supported your child (past or present, such as therapist, psychologist, psychiatrist, speech language therapist, occupational therapist, pediatrician, etc.)?

Please list your child's extra-curricular activities (hobbies, sports, clubs, etc.):

Please describe your child's qualities and strengths:

ACADEMIC

What School-Based Services are currently in place for your child?

_____ None
_____ Reading Recovery
_____ Leveled Literacy
_____ Phonological Awareness Intervention
_____ Speech Therapy
_____ Learning Support Teacher
_____ Program Support Assistant
_____ Behavior Support Teacher
_____ Learning Disability Specialist Teacher
_____ Assistive Technology
_____ Guidance Counsellor
_____ School Mental Health Clinician
_____ Schools Plus Services
_____ Race Relations, Cross-Cultural Understanding and Human Rights (RCH) Services
_____ Child/Youth Support Worker
_____ Individual Program Plan (IPP)
_____ Documented Adaptation (IA)
_____ On-site Tutoring Services
_____ Other (Please Specify):_____

Has your family arranged for private tutoring services to support academic growth outside of school? If yes, who? How often? Targeting which skills?

Describe any difficulties in the following areas:

Reading:

Math:

Writing Ideas on Paper:

Clarity of Pencil-Paper Output (Messy? Hard to read? Clear and organized?)

Behavior Concerns:

Peer Relationships:

Concentration/Attention:

Homework:

Organizational Skills:

Additional comments/questions?

Completed by:

Date: