discovery program, inc

A subsidiary of NILD
National Institute for Learning Development

APPLICATION FOR EVALUATION

Name of Student _____ Date _____

Birthdate _____ Age ____ Grade _____ Sex ____ Teacher _____

Father _____Occupation _____ Work Phone _____

Mother _____ Occupation _____ Work Phone_____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Mother Cell phone _____ Father Cell phone _____

E-mail address_____

Referred by _____

FAMILY HISTORY

Child is living with:

☐ Birth father ☐ Stepfather ☐ Birth mother ☐ Stepmother

☐ Legal guardian ☐ Other _____

Child is: ☐ Adopted ☐ Foster

Since the child's birth there has been: Reaction of child:

☐ Death in the family _____

☐ Separation _____

☐ Divorce _____

☐ Remarriage of mother _____

☐ Remarriage of father _____

☐ Other major trauma _____

Other children in the family:

Name	Age	Grade	Present school
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there a history of learning difficulties in the family? ☐ Yes ☐ No

If yes, please explain: _____

_____

Briefly describe your child's relationship with you, your spouse and other members of the family:

_____

_____

Religious affiliation: _____

MEDICAL/DEVELOPMENTAL HISTORY

Child was: ☐ Full Term ☐ Premature

State any complications that occurred during pregnancy (e.g., toxemia, diabetes, etc.):

_____

State any complications that your child had immediately after birth (e.g., difficulty breathing, blue color, etc.): _____

Check where applicable:

☐ Recent physical exam Date /results _____

☐ Recent eye exam Date/results _____

☐ Recent hearing exam Date/results _____

☐ Recent speech evaluation Date/results _____

Check any problems in infancy or childhood with:

☐ Colic ☐ Talking ☐ Crawling ☐ Walking/running

☐ Sleeping ☐ Bedwetting ☐ Eating ☐ General slow development

Child: (Check where applicable)

☐ Needs glasses ☐ Wears glasses ☐ Has/Had frequent ear infections

☐ Has allergies/ asthma ☐ Has/Had high fevers ☐ Has/Had hearing difficulties

☐ Has/Had seizures, convulsions or staring spells ☐ Experienced injury/accident to the head

Explain any items checked: _____

_____

Is your child presently on medication? ☐ Yes ☐ No

If yes, please identify type, dosage, and explain any noticeable affects of medication on behavior:

_____

_____

EDUCATIONAL HISTORY

List all schools attended (Preschool to present):

School	Grades	Reason for change
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child writes with: ☐ Right hand ☐ Left hand ☐ Both hands

Check where applicable:

- ☐ Repeated grade(s); if so, grade(s) repeated _____
- ☐ Received tutoring; if so, subject(s) _____
- ☐ Enrolled in special class, if so, what kind of class(es) _____
- ☐ Receives/received speech/language therapy
- ☐ Receives/received physical/occupational therapy
- ☐ Received vocational/rehabilitational training

State child's best and worst subjects:

Best _____ Worst _____

Child has been tested before: ☐ Yes ☐ No

If yes, give date and location of testing: _____

Child has been diagnosed as: ☐ ADD ☐ ADHD ☐ Learning Disabled ☐ Other _____

Additional comments or information regarding child's schooling:

_____

_____

State the area(s) in which *you* feel your son/daughter needs help:

_____

_____

SOCIAL/BEHAVIORAL HISTORY

Check areas that apply to your son/daughter:

☐ Independent	☐ Lacks common sense	☐ Stubborn	☐ Dependent
☐ Anxious	☐ Easily distracted	☐ Aggressive	☐ Complains about school
☐ Dishonest	☐ Overly fearful	☐ Withdrawn	☐ Overly sensitive
☐ Shy	☐ Enjoys school	☐ Moody	☐ Self-centered
☐ Passive	☐ Makes friends easily	☐ Confident	☐ Easily frustrated

☐ Prefers playing with much older children ☐ Prefers playing with much younger children

I give permission for Discovery Program to email or fax my child's application for evaluation to the evaluation center. ☐ Yes

I give permission for the _____ evaluation center to email or fax my child's psychological report to Discovery Program, Inc. ☐ Yes

I give permission for the evaluation center of my choice to email or fax my child's psychological report to Discovery Program, Inc. ☐ Yes

I give permission for Discovery Program to share my child's evaluation with his/her school. ☐ Yes

I give permission for Discovery Program to forward my child's evaluation to our pediatrician. ☐ Yes

Pediatrician's name_____ fax number _____

Is there any additional information you would like to personally share with the Discovery Program Director prior to testing? ☐ Yes ☐ No

_____

Parent's signature Date