Child Assessment Questionnaire

Complete and mail (*email is not secure*) to:
Psychology Assessment Center
Hosford Clinic
University of California
Santa Barbara, CA 93106-9490

Considerations for the application/assessment process:

When your application and deposit are received and approved, your name will be held on our wait list. We are staffed by student clinicians supervised by licensed psychologists, so we depend on quarterly attendance of the student clinicians in order to work through our wait list. *This means that it is not possible to give an estimated wait time, though we work diligently to see you as soon as possible.*

Currently the cost of assessment is $800, though the fee is sliding-scale, depending on level of income. The $100 non-refundable deposit is placed towards the total fee. Payment in full is due on the day of your first session, unless otherwise arranged.

The usual process of testing entails 3-4 meetings with a clinician at the center, for 3-4 hours per session (or shorter duration as needed) -- plus a final feedback session. These meetings can be scheduled over one week or many weeks. Testing is done using a compilation of assessments that looks at various aspects of functioning and allows the clinician to construct a thorough report on strengths and challenges, and to generate a list of tailored recommendations.

It usually takes about 1 month to write the report; at the time of its completion, you will be contacted to schedule a feedback session. During the feedback session, you and the clinician will go over the report and recommendations, and any other questions or concerns you might have.

Additional follow-up sessions can be arranged for a fee to help in implementing the recommendations.
Family Version (Completed by: _____________________)

Your relationship to the child: _____________________

IDENTIFYING INFORMATION:

Child’s Name:__________________________________ Handedness:____________

Date of Birth:________________ Age:__________ Ethnicity:_____________________

Today’s Date: _________

Address:  _________________________________________ _____________________

Phone: (Home/Cell)__________________________ (Work) _____________________

E-mail Address: ____________________________________________________________

What is the best way to contact you? __________________________________________

Is it okay for us to leave a message? ___Yes ___No ___Other (please specify): ________

Person to Notify in Case of Emergency: _______________________________________

Phone: _____________________ Relationship to You:__________________________

Person Responsible for Payment: _____________________________________________
(Nota that the PAC does not take insurance, MediCal, or any other third-party payment plans)

REFERRAL INFORMATION:

Who referred him/her for this evaluation? ______________________________________

What information would you like to gain through this evaluation? __________________

__________________________________________________________________________

Any prior psychological or neuropsychological evaluation? ___Yes ___No

Name of Psychologist:____________________ Reason for evaluation and

findings:___________________________________________________________________

__________________________________________________________________________

HISTORY OF CURRENT PROBLEM/INJURY/ILLNESS:

1. Date difficulty started: ___/___/___

2. Please describe in detail the current difficulties or concerns: __________________
How has the child compensated for these difficulties? What strategies or techniques have been helpful?:

3. Please checkmark recent medical tests done and report any abnormal findings:

<table>
<thead>
<tr>
<th>Test</th>
<th>Normal</th>
<th>Abnormal Findings</th>
<th>Test</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI (Brain)</td>
<td></td>
<td>Angiography</td>
<td>CT Scan (Brain)</td>
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<td>Brain SPECT</td>
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<td>EEG</td>
<td></td>
<td>Lumbar puncture</td>
<td>Skull X-Ray</td>
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<td>Ultrasound</td>
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<tr>
<td>PET Scan</td>
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<td>Other Tests:</td>
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</table>

4. How many **hours of sleep** does he/she normally get?_______

Does he/she experience: **insomnia**______ trouble with **waking** at night_____
Other problems:__________________________________________

5. Please list any medications, supplements, or herbal products he/she **currently** takes:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
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<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>5.</td>
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**BIRTH AND DEVELOPMENTAL HISTORY:**

1. Was he/she born: ____ on time, ____ prematurely, or ____ late?

2. What was his/her **birth weight**? ____ lbs., ____ oz.
3. Please describe any problems you are aware of that were associated with birth or the immediate time period after birth:
   ____ oxygen deprivation, ____ unusual birth position,
   other (please describe): ________________________________

4. Any illnesses or complications during pregnancy?  ____Yes  ____No
   (please describe): ____________________________________________

5. Please check all that applied to his/her mother while she was pregnant with him/her:
   ____ Alcohol use     ____ Cigarette smoking
   ____ Recreational or street drug use  ____ Malnutrition
   ____ Exposure to environmental toxins  ____ Accidents

6. Medications (prescribed or over-the-counter) taken by the mother during pregnancy: ________________

7. Drugs (Illegal) taken by the mother during pregnancy: Please describe type of drug, frequency of use, and at what month of pregnancy use was stopped:

8. Please describe the child as an infant (i.e., temperament, sleeping, eating habits, etc.):

9. Did his/her developmental progress, such as walking and talking, occur
   ____ early, ____ average, or ____ late?

10. As a child, did he/she have any developmental problems?  ____Yes,  ____No. If so, please describe:

11. As a child, did he/she have any attention problems?  ____Yes,  ____No. If so, please describe:

12. As a child, did he/she have any learning difficulties?  ____Yes,  ____No. If so, please describe:

13. As a child, was he/she around any toxic waste, toxic fumes of any kind, or lead?
   ____ Yes /  ____ No. If yes, please explain: ____________________________


14. Describe the child’s **eating habits** and **nutrition**:

________________________________________________________________________

________________________________________________________________________

**CHILD’S MEDICAL AND PSYCHIATRIC HISTORY:**

1. Please describe any **concussion/loss of consciousness** or other brain injury:

________________________________________________________________________

2. Please describe any **previous** hospitalization, neurologic illness, serious injury, or surgery:

________________________________________________________________________

3. Please list any **other illnesses or health problems** he/she has ever had:

________________________________________________________________________

________________________________________________________________________

4. Please describe any history of **alcohol** or **drug** use by the child:

________________________________________________________________________

________________________________________________________________________

5. Please describe any **mental health problems or diagnoses** he/she has ever had:

________________________________________________________________________

________________________________________________________________________

6. Please describe any **mental health treatment** he/she has ever received:

________________________________________________________________________

________________________________________________________________________

7. Do you see this child as being:

_____ Hyperactive  _____ Inattentive  _____ A behavior problem

Describe behavior problems:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

8. Does the child receive any special services (e.g., Regional Center, CPS, etc.)?  
_____ Yes _____ No. If yes, provide name of agency, worker and phone number:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

9. Date of last **eye** exam: __________. Were results normal?  ____ Yes  ____ No.
   If no, please explain: ____________________________________________________
10. Date of last hearing exam: __________. Were results normal? ___Yes ___No. If no, please explain: ______________________________________________________

11. Family Medical History: Describe any psychiatric, neurological, substance abuse, or academic problems that close relatives have had:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Child</th>
<th>Problem</th>
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<tbody>
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4. Describe child's relationships with others: ______________________________________________________

5. Please describe the child's typical daily activities and interests: ______________________________

6. What help or supervision does he/she need from others? ________________________________________

EDUCATIONAL AND CULTURAL BACKGROUND:

1. What is his/her primary language?: ____________________________________________________________

2. What is his/her cultural or ethnic background?: ________________________________________________

3. What is the highest grade that he/she completed in school? ____________________________

4. Was he/she labeled as "learning disabled" or placed in any special education classes? ___Yes, ___No. If yes, please describe: ______________________________________________________

5. Did he/she have any behavioral or disciplinary problems in school? ___Yes, ___No. If yes, please describe: ______________________________________________________

6. Did he/she repeat any grades? ___Yes, ___No. If yes, please describe: __________________________

7. What were his/her best subjects? _____________________________________________________________

8. What were his/her worst subjects? ___________________________________________________________
9. As a student, was he/she
_____ average, _____ above average, or _____ below average?

10. Please describe any grade point averages or standardized test scores
(e.g., SAT, IQ, achievement tests, etc.) that he/she earned: ______________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________

11. Please describe any special accomplishments or strengths as a student: ___
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________

CURRENT LIVING SITUATION:

1. Child is living with:
   ☐ Both Parents
   ☐ Mother
   ☐ Father
   ☐ Mother & Stepfather
   ☐ Father & Stepmother
   ☐ Legal Guardian (please specify): _______________
   ☐ Other (please specify): _______________

2. Other people in household (please list name, age, and relationship to child if any):
   Name:      Age:    Relationship:
   ____________________________________________________
   ____________________________________________________
   ____________________________________________________
   ____________________________________________________
   ____________________________________________________
   ____________________________________________________
   ____________________________________________________
   ____________________________________________________
   ____________________________________________________
   ____________________________________________________

Child’s Personality and Behavior:
Please circle all traits that currently describe the child:

Independent     Dependent     Moody
Leader | Follower | Sad
---|---|---
Affectionate | Prefers to be alone | Trouble sleeping
Even-tempered | Too responsible | Hard to discipline
Happy | Quiet | Fearful
Cooperative | Lethargic | Tantrums
Friendly | Sensitive | Overactive

**PROBLEMS:**

Please describe the problems he/she is having now and indicate whether he/she had these problems before his/her injury or illness. If their difficulties are not related to an illness, injury, or other condition, just indicate what problems he/she has now.

1. Difficulty with **problem solving or reasoning**?
   If so, please describe: ______________________________________________________
   Now ______  Before ______

2. Problems with **speed of thinking**?
   If so, please describe: ______________________________________________________
   Now ______  Before ______

3. Problems with **concentration**?
   If so, please describe: ______________________________________________________
   Now ______  Before ______

4. Problems with **memory**?
   If so, please describe: ______________________________________________________
   Now ______  Before ______

5. Problems with **speaking, listening, writing, or reading**?
   If so, please describe: ______________________________________________________
   Now ______  Before ______

6. Problems with **strength or coordination**?
   If so, please describe: ______________________________________________________
   Now ______  Before ______
7. Problems with **vision**? If so, please describe: ___________________________ __

8. Problems with **spatial** ability or sense of direction? If so, please describe: ___________________________ __

9. Problems with sense of **hearing, touch, or smell**? If so, please describe: ___________________________ __

10. Problems with **psychological or social adjustment** or aspects of his/her life that are **stressful**? If so, please describe: ___________________________ __

Please provide any other relevant information here:
I certify that I have read the Psychology Assessment Center’s policies and procedures (http://education.ucsb.edu/pac/policies.html), including the limits of confidentiality, security deposit, and fee information and agree to these conditions for the duration of my professional relationship with the PAC should I be deemed appropriate for an evaluation. I understand that the fee for services is $800 unless I have been approved for a fee reduction.

Signature ___________________________ Date ______________________

I have included my non-refundable $100 security deposit payable to “UC Regents.”