FAMILY ATTACHMENT & ADOPTION CENTER EAST BAY
1425 LEIMERT BLVD., SUITE 302-A
OAKLAND, CA 94602
WWW.ATTACHMENTADOPTION.NET

Child's Name_____Birthdate_____Age____Sex___
Last First Middle

If adopted:
Age at adoption_____Country of Origin_____ Open or Closed Adoption *(circle)*

Foster care: Yes/No Time in foster care: **Institutional care**: Yes/No Time in institution:

Home Address _____
Street City State Zip

Home phone_____Other daytime/cell phones_____

E-mail address(es):_____

Name of person(s) filling out this form:_____
Relation to child

Child's School _____
Name Street City State/Zip

Grade:_____ Teacher's name_____School phone_____

Present Placement of child (please check in appropriate bracket):

	Column A *Adults with whom child is living*	**Column B** *Non-residential adults involved with child*
Adoptive mother	( ) _____	( ) _____
Adoptive father	( ) _____	( ) _____
Foster mother	( ) _____	( ) _____
Foster father	( ) _____	( ) _____
Birth mother	( ) _____	( ) _____
Birth father	( ) _____	( ) _____
Stepmother	( ) _____	( ) _____
Stepfather	( ) _____	( ) _____
Other (specify) _____	_____	_____
Other (specify) _____	_____	_____

Place the number 1 or 2 next to each person checked in Column A who is most involved with the child and provide the following information about each person:

1. Name_____Occupation_____

Business Name _____Business Address_____

_____Business Phone_____

2. Name_____Occupation_____

Business Name _____Business Address_____

_____Business Phone_____

Place the number 3 next to the person checked in Column B who is most involved with the child and provide the following information:

3.Name_____Home address_____

_____Home phone_____

Occupation_____Business Name _____

Business
Address_____BusinessPhone_____

SOURCE OF REFERRAL
Name_____Address_____

_____Phone_____

PURPOSE OF CONSULTATION (BRIEF SUMMARY OF CHILD'S MAIN ISSUES):
How long been a concern to you? When first noticed?

WHAT DO <u>YOU</u> THINK MAY ABE CAUSING THE PROBLEM(S)?

WHAT HAVE YOU TRIED TO DO IN THE PAST TO DEAL WITH THE PROBLEM(S)? What seems to help? What seems to make the problem worse?

Has this child had previous evaluations/psychotherapy/testing/IEP (Individualized Education Plan)? YES/NO
If YES, what were the results and conclusions? (Please include copies of the test reports).

LIST NAMES, ADDRESSES AND PHONE NUMBERS OF ANY OTHER PROFESSIONALS CONSULTED.

1.

2.

3.

4.

Describe 3 noteworthy (favorable or unfavorable) events which have occurred in this child's life during the past year. (If there were no noteworthy events, describe 3 things which happened even if they were unremarkable.)

1.

2.

3.

CHILD'S DEVELOPMENTAL HISTORY

Was there prenatal care?

Were there any known prenatal complications? YES/NO. If so, please specify:

Violence or Abuse during pregnancy?

Smoking during pregnancy?

Alcohol consumption during pregnancy? Describe, if beyond an occasional drink:

Medications (prescribed or onver-the-counter_ or injections received during pregnancy if known:

List any other drugs used during the birth mother's pregnancy:

	Amount	**How often**	**During which month(s) of Pregnancy (if known).**
Cocaine			
Crack			
Heroin			
Speed/Crank			
Marijuna			
Other (Specify)			

DELIVERY

Was the baby on time? Early? Late? By how many weeks? Days?

Type of labor: Spontaneous Induced Duration of labor _____ hours

Type of delivery: Normal Breech Caesarean

Complications during delivery (specify):

Birth Weight _____lbs _____ozs. Length_____

Appropriate for gestational age_____

Small for gestational age_____

POST-NATAL PERIOD (while in hospital)
Respiration: immediate_____ delayed (if so, how long?)_____

Cry: immediate_____ delayed (if so, how long?)_____

Number of days baby in hospital _____ In incubator or intensive care? ____ number of days_____

After delivery, any difficulty with: _____poor suck/feeding, _____breathing, _____illness,

_____seizures, _____positive drug screen, _____drug withdrawal, _____other (specify)

_____

Total number of days baby was in the hospital after the delivery _____

INFANCY-TODDLER PERIOD
Were any of the following present—to a significant degree—during the first few years of life. If so, describe.

Did not enjoy cuddling_____

Was not calmed by being held and/or rocked_____

Colic_____

Excessive restlessness_____

Diminished sleep because of restlessness and easy arousal_____

Frequent headbanging_____

Rocking_____

Masturbation_____

Constantly into everything_____

Excessive number of accidents compared to other children_____

CURRENT CAREGIVER ARRANGEMENTS
Please list your child's current caregivers throughout the day:

In child's home by:	% of day	Out of home care:	% of day
Parent or relative		In day care home	
Babysitter		In nursery school	
		In kindergarten/grade school	
		In after school program	
		Other_____	

DEVELOPMENTAL MILESTONES
If you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall, check item at right.

		I cannot recall exactly, but to the best of my recollection, it occurred:		
	Age	**Early**	**At the normal time**	**Late**
Smiled				
Sat without support				
Crawled				
Stood without support				
Walked without assistance				
Spoke first words besides "ma-ma" and "da-da"				
Said phrases				
Said sentences				
Speech is clear to family members and strangers				
Understood "no" or "stop it"				
Could follow a simple command				
Bowel trained, day				
Bowel trained, night				
Bladder trained, day				
Bladder trained, night				
Rode tricycle				
Rode bicycle (without training wheels)				
Buttoned clothing				
Tied shoelaces				
Named colors				
Named coins				
Said alphabet in order				
Began to read				

COORDINATION
Rate your child on the following skills.

	Good	Average	Poor
Walking			
Running			
Throwing			
Catching			
Shoelace tying			
Buttoning			
Writing			
Athletic Abilities			

COMPREHENSION AND UNDERSTANDING
Do you consider your child to understand directions and situations as well as other child his or her age?___

If not, why not?_____

How would you rate your child's overall level of intelligence as compared to other children?

Below average_____ Average_____ Above Average_____

SCHOOL
Please list the names of the schools your child has attended from nursery school through the present:

_____

Rate your child's school experience related to academic learning. **Good** **Average** **Poor**

Nursery School_____

Kindergarten_____

Current Grade_____

To the best of your knowledge, at what grade level is your child functioning:

Reading_____ Spelling_____ Mathematics_____

Has your child ever had to repeat a grade? _____ If so, when_____

Present class placement: regular class_____ special class (if so, specify)_____

Kinds of special therapy or remedial work your child is currently receiving_____

Describe briefly any academic school problems_____

Rate your child's school experience related to behavior:

	Good	Average	Poor
Nursery School			
Kindergarten			
Current Grade			

Does your child's teacher describe any of the following as significant classroom problems?

Doesn't sit still in his or her seat_____

Frequently gets up and walks around the classroom_____

Shouts out. Doesn't wait to be called upon_____

Won't wait his or her turn_____

Does not cooperate well in group activities_____

Typically does better in a one-to-one relationship_____

Doesn't respect the rights of others_____

Doesn't pay attention during storytelling_____

Describe briefly any other classroom behavioral problems:_____

PEER RELATIONSHPS

Does your child seek friendships with peers?_____

Is your child sought by peers for friendship?_____

Does your child play primarily with children his or her own age?_____ younger?_____ older?_____

Describe briefly any problems your child may have with peers_____

HOME BEHAVIOR

All children exhibit, to some degree, the kinds of behavior listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her age.

Hyperactivity (high activity level) _____

Poor attention span _____

Impulsivity (poor self control) _____

Low frustration threshold _____

Temper outbursts _____

Sloppy table manners _____

Interrupts frequently _____

Doesn't listen when being spoken to _____

Sudden outbursts of physical abuse of other children _____

Acts like he or she is driven by a motor _____

Wears out shoes more frequently than siblings _____

Heedless to danger _____

Excessive number of accidents _____

Doesn't learn from experience _____

Poor memory _____

More active than siblings _____

INTERESTS AND ACCOMPLISHMENTS

What are your child's main hobbies and interests? _____

What are your child's greatest accomplishments? _____

What does your child enjoy doing most? _____

What does your child dislike doing most? _____

Please list other strengths you see in your child _____

_____

MEDICAL HISTORY
If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

Childhood diseases (describe any complications) _____

Operations or hospitalizations _____

Trauma (lacerations, fractures, serious accidents) _____

Head injuries _____with unconscious _____ without unconscious _____

Convulsions _____with fever _____ without fever _____

Coma _____Poisoning (e.g. lead) _____

Persistent high fevers _____Highest temperature ever recorded_____

Other past medical problems (specify) _____

PRESENT MEDICAL STATUS
Present height_____ Present weight _____

Do you have any concerns about this child's eating habits, diet, nutrition or growth? _____If so, please explain. _____

Vision problems _____

Hearing problems _____

Use of glasses, hearing aids, or prosthetic devices _____

Present illness(es) for which child is being treated _____

_____

Medications child is now taking on an ongoing basis _____

_____

Are there any observable side effects of the current medication(s)? _____

_____

Other present medical problems (specify) _____

_____

FAMILY HISTORY – MOTHER/Parent

Current Age _____ Age at time of the patient's birth/adoption _____

School: Highest grade completed _____

FAMILY HISTORY – FATHER/Parent

Current Age _____ Age at the time of the patient's birth/adoption _____

School: Highest grade completed _____

Have the child's parrent's ever had:

Learning problems (specify):

Behavior problems (specify):

Medical problems (specify)

CHILD'S SIBLINGS

Name	**Age**	**Medical, social, or academic problems**
1.		
2.		
3.		
4.		
5.		
6.		

BIRTH FAMILY HISTORY

Have any of the child's birth relatives ever had problems similar to those your child has? If so, describe

_____

_____

Learning problems (specify):

Behavior problems (specify):

Medical problems (specify)

OTHER COMMENTS

Please use this space to share any other information about your child that would be helpful to treatment.