Atlanta Educational Consultants

Adolescent Information Form

Today's Date______________________

Person Completing Form____

Name of Student____

Name of Parents or Guardian____

Mailing Address____
(Street) (City) (State, Zip)

Home Telephone ____________________ Cell (Mom)__________________________

Cell (Dad)___________________________

Student's Date of Birth ________________ Current Grade in School_______________

Mother's e-mail address ____

Father's email address____

Current School: ____

Address:____

Year of High School Graduation:___________ Currently in Grade:_____________

School Guidance Counselor____________________________________

Academic Advisor (*if different)* _________________________________

School Phone: (_____)__________________ School Fax: (____)_______________

List all previous schools attended and include grades:

_________________________________ _____________________________

_________________________________ _____________________________

_________________________________ _____________________________

Student lives with (Check all that apply):

____ Father ____Stepfather ____Guardian

____Mother ____ Stepmother

____Other (Please specify) ____________

Check any that apply: ____ Child is Adopted

____Father is deceased ____Parents divorced

____Mother is deceased ____Parents separated

____Father remarried ____Mother remarried

If married, how long have you been married?______________________________________

If divorced, how long have you been divorced? ____________________________________

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If divorced, who has physical custody? ____

Who has legal custody?____

Father's occupation____________________ Mother's occupation: _____________________

Business address ____

Business address ____

Telephone___________________________ Telephone ______________________________

Educational Background

	Mother	Father
High School	________________________	_________________________________
College	___________________________	_________________________________
Adv. Degrees	_______________________	_________________________________

Student History

Educational History

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REASON FOR REFERRAL

Please describe the type of services you are seeking. If applicable, please describe any problems your child is now having>

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Past disciplinary problems (smoking, drugs, alcohol, school disruptions):

____

____

Documented Learning Disabilities: Need for accommodations:

____

____

Please indicate if your child is experiencing any of the following difficulties:

___________School attention/concentration problems

___________Grades dropping or consistently low

___________Hyperactive, difficulty being still

___________Sadness or Depression

___________Generalized Anxiety (across many situations)

___________Specific Fears or Phobias (List)____

___________Obsessive-Compulsive / Rigid behavior patterns

___________Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)

___________ Isolated socially from peers

___________Problems making or keeping friends

___________Problems with eating

___________Problems falling asleep

___________Problems sleeping through the night (middle of the night or early morning waking)

___________Trouble waking up

___________Fatigue/tiredness during the day

___________Nightmares

___________Noncompliant, purposely does not obey (not due to language or cognitive deficits)

___________Oppositional, defiant behavior

___________Problems controlling temper

___________Tantrums / "Meltdowns"

___________Problems with authority (breaking rules or laws)

___________Physically aggressive behavior towards others (biting, pinching, scratching, kicking, fighting)

___________Verbally aggressive behavior towards others (name-calling, screaming, swearing, unkind comments)

___________Self-injurious / Self-harm behavior (head banging, scratching, biting, cutting self)

___________Wetting accidents (indicate day or night wetting):

___________Soiling accidents or other bowel problems (withholding, refusal, fear/anxiety)

___________History of abuse (emotional, physical, sexual)

___________Alcohol or drug use/abuse

___________Vocal or motor tics (e.g, grunts, squeals, eye blinks, throat clearing, grimacing, involuntary movements)

___________Sensory problems (over-reacts or under-reacts to lights, sounds, tastes, textures, smells)

___________Stress from conflict between parents

___________Stress due to family financial problems

___________Legal situation (anyone in family)

Other behavior problems____

MEDICAL HISTORY

Name of Child's Primary Physician: ____

Physician's Address:____

Physician's Phone: ____

List any other physicians or health professionals your child sees for services on a regular basis

(Psychiatrists, Therapists, Occupational Therapists, Speech Pathologists, etc.)

____

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When was your child last seen by a physician?

Rate your child's overall health _____Excellent _____Good _____Fair _____Poor

Child's current height: ______ft, ______in. Weight_______________________

Does your child have any vision problems?______________________________

Date of last vision test and who performed (physician, optometrist, school)

Does your child have any hearing problems?_______________________

Date of last hearing test and who performed (physician, audiologist, school)____

Is your child: _____right handed _____left handed _____does not favor one hand

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other medical conditions your child has had.

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List any medications your child is currently taking, including over-the-counter drugs, vitamins, and other nutritional supplements (include dosages). Also list previous medications and dates if taken for an extended period of time.

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Social and Educational History

Name of current teacher (s):____

What concerns does your child's teacher have about him/her?___________________________

____

What is your child's favorite subject?____

What is your child's least favorite subject?____

Has your child ever repeated a grade?_________________________________

Has your child ever skipped a grade?__________________________________

Has your child ever had tutoring?_____________________________________

When and with whom?____

Has this child ever been in a Special Education Program?___________________

How much of the school day?____

What type of program? (LD, Gifted, EBD, ASD, etc.)______________________

Child's attitude toward school:____

____

How does your child interact with peers and adults in social situations?_________

____

Do you have concerns about your child's social skills or development?_____________

____

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What is your child most interested in? ____

____

List your child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.____

____

____

Describe your child's strengths, positive qualities, and any special abilities or skills.

____

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What do you see as the student's best qualities? ____

____

____

What are the student's greatest problems or handicaps? ____

____

____

Additional Comments____

____

____

____

____

Religious preference of Student (optional)____

Referred by: ____

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