



NEW CLIENT QUESTIONNAIRE

Date

CONTACT INFORMATION

Student Name

Gender

Date of Birth

Home Phone

Parent/Guardian

Cellphone

Email

Parent/Guardian

Cellphone

Email

Parent/Guardian

Cellphone

Email

Adult Student

Cellphone

Email

Student Address:

City

State

Zip

Who completed this form?

REFERRAL CONCERNS

What concerns do you have about the student?

What do you hope to gain from visiting our center?

How did you hear about Turning Points Educational Solutions?

School Staff Friend Physician Therapist Tutor Ad Website Name:

CLIENT'S HEALTH HISTORY

Yes No

If yes, please explain.

General symptoms.....
(fever, weakness, tiredness, etc.)

Trouble with eyes/glasses Date last checked:
Be sure to bring glasses to assessment

If glasses: Distance Near

Trouble with ears/hearing Date last checked:
Please forward any audiology reports

Ear infections.....

Tics, twitches, or makes odd noises.....

Headaches.....

Loss of consciousness/head injury.....

Seizures/Convulsions.....

Body stiffness or floppiness.....

Wets underwear during day/night.....

Soils underwear/bowel accidents.....

Allergies/Asthma.....

Please describe any other
health related issues:

Yes No

Dates

Purpose

Hospitalizations

Surgeries

MEDICATION HISTORY

Past Medication(s)

<i>Name of medications and reason used in the past:</i>	Dosage(s)	Dates
.....		
.....		
.....		
.....		

Current Medication(s) including vitamins/supplements

<i>Names of medications and reason for taking</i>	Dosage(s)	Dates
.....		
.....		
.....		
.....		

SLEEP HISTORY

	Yes	No	If Yes, Please Explain.
Does the student have trouble falling asleep at night?.....			
Does the student have problems staying asleep?.....			
Does the student snore?.....			
Does the student have very heavy sleep?.....			
Does the student nap during the day?			
Does the student have frequent nightmares?.....			
Number of minutes needed to fall asleep.....			
What time does student go <u>to sleep</u> on school nights?.....			
What time does student wake up on school days?.....			
Is it hard for him/her to get up in the morning?.....			

DEVELOPMENTAL HISTORY AND MILESTONES

	Month	Additional Details
Rolled Over.....		
Sat up without support.....		
Crawled.....		
Used first real words (not babbling).....		
Walked alone.....		
Put two words together.....		
Used 2-3 word sentences.....		

DEVELOPMENTAL HISTORY AND MILESTONES

(Continued)

Month

Additional Details

Fully bladder trained.....
Fully bowel trained.....
Caught a big ball.....
Spoke clearly enough for strangers to understand.....
Able to dress self.....
Able to tie shoelaces.....

SPEECH AND LANGUAGE HISTORY

Listening

Yes

No

Does the student have difficulty listening to verbal information?.....
Does the student misunderstand verbal directions?.....
Does the student confuse speech sounds?.....
Does the student misunderstand jokes, sarcasm, or idioms?.....

Speaking

Does the student have difficulty articulating speech sounds correctly?.....
Does the student have slow/halting speech?.....
Does the student jumble up sounds in words?.....
Does the student have difficulty expressing his/her thoughts clearly?.....

Language

Was your child slow to acquire fluency in their native language?.....
Have you or your children lived in other countries?.....
If yes, what countries/dates?
Which languages are spoken at home?.....
If more than one, indicate the percentage each language is spoken at home.....
What was the student's first language?.....
What language does the student most often speak now?.....
In what language has your child received educational instruction?
Please list grades and language.....
What percentage does the student understand in the home language?.....
What percentage does the student understand in English?.....
What percentage does the student speak in the home language?.....
What percentage does the student speak in English?.....
List any CELDT scores by grade level.....

BEHAVIOR HISTORY

Emotional Response

Yes No If yes, please describe

Does the student have meltdowns?.....

Is the student physically aggressive toward others/objects? At school, home, both?.....

Is the student verbally aggressive toward others?.....

Mood

Does the student frequently appear sad or irritable?.....

Is the student uninterested in participating in many activities?.....

Does the student make negative comments about him/herself?.....

Is the student withdrawn from family and/or friends?.....

Has the student talked of harming him/herself?.....

Has the student attempted to harm him/herself?.....

Anxiety

Does the student worry frequently?.....

Does the student complain of unfounded illness or pain?.....

Does the student avoid going to school? Is so, for what reasons?.....

Does the student have more fears than other students his/her age do?.....

Obsessions, Compulsions or Perseverations

Does the student insist upon doing things a certain way?.....

Does the student have difficulty making transitions?.....

Does the student perform repetitive movements such as rocking or flapping?.....

Does the student line up his/her toys?.....

Social Skills

Does the student have difficulty conversing with others?.....

Does the student have difficulty understanding the body language of others?.....

Does the student have difficulty making eye contact?.....

Does the student have problems understanding other's beliefs or intentions?.....

Does the student have difficulty making close friends?.....

Sensory Processing

Does the student frequently bump into things, trip or fall?.....

Is the student a picky eater? If so, what foods does he/she avoid?.....

Is the student overly sensitive to certain sounds? Please list:

Does the student show aversion to textures? Please list:.....

ATTENTION HISTORY

	Yes	No	If yes, please describe
Mental Energy			
Is the student often tired during the day? Morning, evening, all day?.....			
Does the student attend/focus inconsistently?.....			
Does the student have difficulty beginning or completing work?.....			
Does the student perform inconsistently in school?.....			
Processing Controls			
Is the student easily distracted?.....			
Does the student miss parts of explanations and directions?.....			
Do instructions have to be repeated to the student?.....			
Does the student have difficulty remembering recently learned information?.....			
Does the student frequently daydream?.....			
Does the student have difficulty concentrating?.....			
Does the student have difficulty delaying gratification or waiting their turn?.....			
Production Controls			
Does the student behave impulsively?.....			
Does the student have difficulty staying on task?.....			
Does the student have difficulty recognizing errors or learning from mistakes?.....			
Are punishments or rewards effective with the student?.....			
Executive Functioning			
Is the student's room frequently messy?.....			
Is the student's backpack or locker frequently messy?.....			
Does the student procrastinate/have trouble starting tasks?.....			
Does the student lose personal items (phone/uniforms/tablet, etc.)?.....			
Does the student have difficulty writing down/keeping track of assignments?.....			
Is a system used for homework (agenda/online, etc.)?.....			
Does the student lose/forget to do homework?.....			
Does the student lose/forget to turn in completed work?.....			
Does the student have difficulty planning for projects/tests?.....			
Does the student make careless errors in work?.....			
Does the student have difficulty prioritizing work?.....			
Does the student have difficulty estimating how long tasks will take?.....			
Does the student have difficulty completing work/tasks on time?.....			

EDUCATION HISTORY

Current School and District

Grades Attended

School Contact #

All Previous Schools and Districts

Grades Attended

EDUCATIONAL SERVICES**Yes No Year/Grade/Assessors**

Has the student been tested by a school?

If so, please list dates and by whom.....

Has the student had any private evaluations?

If so, please list dates and who the student was tested by.....

Has the student repeated any grades? Please list:.....

Does the student have a 504 or accommodation plan?.....

Does the student have an Individualized Education Plan (IEP)?

Is the student receiving educational support outside of school?

Has the student's attendance been regular?.....

About how much time does the student spend on homework daily?.....

Please list all previous school/private interventions:

(Tutoring, speech, OT, PT, therapy, etc).....

Please list all current school/private interventions:.....

LEARNING**Has the student ever had any difficulty learning any of the following?****Yes****No****Check if
continuing concern**

The alphabet.....

Days of the week/Months of the year

Telling time

Sounding out words

Spelling accurately.....

Understanding what they read

Reading fast enough

Writing neatly/handwriting

Performing math calculations

Understanding math word problems

Writing reports

Remembering instructions for an assignment

Knowing how to study for a test

Recalling information during tests

Managing homework.....

FAMILY HISTORY	Mother	Father	Brother(s)	Sister(s)	Other Relatives
Learning difficulties					
Trouble paying attention					
Hyperactivity					
Autism Spectrum Disorders					
Speech problems					
Cognitive impairment					
Drug or alcohol abuse					
Depression					
Anxiety/Compulsions					
Mania					
Other: (Please List. If none, please state n/a)					

WHO LIVES IN THE HOUSE WHERE THE STUDENT RESIDES?

Name	Relationship	Age	Occupation/Grade

FAMILY SUPPORTS	Yes	No	If yes, please explain
Does the student have siblings that are not living at home?			
Is the student adopted?			
Is the student in foster care?			
Are the parents separated?			
Are the parents divorced?			
If separated or divorced, since when?			
Who has legal custody of the student? Please list:			

GENERAL INFORMATION

Describe the student's interests:

What are the student's strengths and talents?

Please include any other information you might think valuable:

Please attach copies of report cards since kindergarten, standardized test scores, current IEP, and all previous evaluations.

PROFESSIONAL SUPPORTS

Please list the other clinicians caring for the student (e.g. counselors, physicians)

Check if we should send them a copy of report

Name	Specialty	Address	Phone
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RETURN COMPLETED FORM TO TURNING POINTS EDUCATIONAL SOLUTIONS

1261 Lincoln Avenue, Suite 104

San Jose, CA 95125

info@turningpointsted.com

If you have questions, please call: 408-439-1111

Turning Points Educational Solutions provides services for individuals of all ages who may have learning differences and/or socio-emotional difficulties. We also provide psycho-educational/school neurological assessments, educational therapy, psychotherapy and more. Please 'like' our Facebook page for educational information and updates.