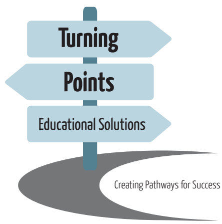

New Client Questionnaire

Date

CONTACT INFORMATION

Student Name Gender

Date of Birth

Home Phone

Parent/Guardian Cellphone Email

Parent/Guardian Cellphone Email

Parent/Guardian Cellphone Email

Parent/Guardian 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:

MEDICAL HISTORY

Biological Mother's Pregnancy History	Yes	No	Month(s) of Pregnancy	If yes, please explain.
Bleeding during the pregnancy				
High blood pressure				
High blood sugar/diabetes				
Physical trauma				
Maternal infections				
Maternal alcohol use				
Maternal tobacco use				
Exposure to other substances				
Previous miscarriages				
Previous premature births				
Cesarean section and reason				
Forceps delivery				

Please describe any other complications:

Length of pregnancy	weeks	
Twins?	Fraternal	Identical
Birth Weight	lbs.	oz.
Birth Length	in.	
Apgar Scores	1 min	5 min
Labor	Spontaneous	Induced

CLIENT'S NEWBORN HISTORY	Yes	No	If yes, please explain.
Newborn jaundice			Describe any method of treatment:
Stayed in the newborn intensive care unit			How long?
Transfusion			
Required oxygen			How long?
Intubation			
Was the infant discharged with mother?			If no, length of infant's hospital stay:

Describe any other difficulties following delivery:

CLIENT'S HEALTH HISTORY

	Yes	No	If yes, please explain.
General symptoms (fever, weakness, tiredness, etc.)			
Trouble with eyes/glasses *Be sure to bring glasses to assessment*			Date last checked: If glasses: Distance Near
Trouble with ears/hearing *Please forward any audiology reports*			Date last checked:
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)

Name of medications and reason used in the past:	**Dosage(s)**	**Dates**

Current Medication(s) including vitamins/supplements

Names of medications and reason for taking	**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 take frequent naps 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 MILSETONES

	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

Mental Energy	Yes	No	If yes, please describe
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 had any difficulty learning any of the following?	**Yes**	**No**	**Check if ongoing**
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

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

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?			

List all people who share educational rights for the student:

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 kindergartnen, standardized test scores, current IEP, and all previous evaluations.

PROFESSIONAL SUPPORTS

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

Name	Specialty	Address	Phone	Check if we should send them a copy of report

RETURN COMPLETED FORM TO TURNING POINTS EDUCATIONAL SOLUTIONS

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San Jose, CA 95125

info@turningpointsed.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.