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EVALUATION FORM

CLIENT INFORMATION

Name of client: _____

Date of birth: _____ Home Phone: _____

Home address: _____

PARENT (S)/ CAREGIVER

Name: _____ Relationship: _____

Email: _____ Phone: _____

Name: _____ Relationship: _____

Email: _____ Phone: _____

☐I give permission to Dr. Frank to email general client information. Initials_____

☐ I give permission to Dr. Frank to leave me a voice mail message. Initials_____

☐ I give permission to Dr. Frank to send me a text message. Initials_____

Please list a password that you will use to open emails from Dr. Frank. _____

SCHOOL / DAYCARE CENTER

Name: _____ Teacher's Name: _____

Grade: _____ Phone: _____

Address:_____

PEDIATRICIAN

Name: _____ Phone: _____

Address: _____

EMERGENCY CONTACT

Name: _____ Phone: _____

Relationship: _____

CURRENT CONCERNS AND FUNCTIONING

Reason for referral*: (What do you hope to accomplish in therapy?)*

_____

_____

_____

Check the concerns (if any) which apply to the client:

• Behavioral and emotional functioning

□aggression	□oppositional	□sadness
□high activity level	□tantrums	□difficulty separating
□impulsivity	□non-compliant	□withdrawn
□stealing/lying	□cutting/self-injurious behavior	□sleep disturbance
□inattentive	□anxiety/fears	□eating disturbance

Other / describe _____

• Developmental functioning

Suspected difficulties with:

□speech/language □motor development □pre-academic skills □sensory processing

Other / describe_____

• Academic functioning

Suspected difficulties with: □reading □writing □spelling □mathematics

• Other concerns *(please describe)* _____

Has the child been previously evaluated?

(please include copies of any previous evaluation) □Yes □No

If yes:
Where_____

When _____

Family functioning (family in which the child resides)

Please list immediate family members and other people who are important to your child.

(List additional family members on back)

Name _____ Age _____ Relationship to child _____

Name _____ Age _____ Relationship to child _____

Name _____ Age _____ Relationship to child _____

Please list any strengths or weaknesses in familial relationships and general family functioning.

_____

_____

_____

_____

Please list any current family stressors or significant changes in the child's life.

_____

_____

_____

Please describe child's attachment to the primary caregiver(s).

_____

other caregivers? _____

How does the child tolerate separations from caregivers?

_____

Social functioning

How does the child get along with peers? _____

Difficulties in the following areas:

☐playing ☐communicating ☐fighting ☐physical ☐verbal

Strengths – please list three

1) _____ 2) _____ 3) _____

CLIENT HISTORY

MEDICAL HISTORY

Please list any allergies, surgeries, chronic illnesses, hospitalizations, medications

_____

_____

BIRTH HISTORY

Born full term: ☐yes ☐no Exposure to substances: ☐yes ☐no

Complications during pregnancy or delivery: ☐yes ☐no Medical problems at birth: ☐yes ☐no

Please describe any problems: _____

Adoption: ☐Yes ☐No age: _____

Circumstances: ☐domestic ☐foreign ☐open adoption ☐closed adoption

THERAPY/TREATMENT HISTORY

(please include treatment goals, dates of treatment, therapist, and treatment progress)

Psychotherapy: _____

Speech and language therapy: _____

Physical therapy: _____

Occupational therapy: _____

Tutoring: _____

FOR CHILDREN IN FOSTER CARE/ADOPTION

Placement history

Describe abuse or neglect _____

_____

First foster home/placement:

date placement began: _____

name of caregiver: _____

relationship to child: _____

date left first placement: _____

reason for change in placement: _____

Second foster home/placement:

date placement began: _____

name of caregiver: _____

relationship to child: _____

date left second placement: _____

reason for change in placement: _____

Third foster home/placement:

date: _____

name of caregiver: _____

relationship to child: _____

date left second placement: _____

reason for change in placement: _____

Visitation with birth family

Visits/contact with birth mother □yes □no

frequency: _____

where are visits held? _____

_____

child's reactions to visits: _____

_____

birth mother's reactions to visits: _____

_____

Visits/contact with birth father □yes □no

frequency: _____

where are visits held? _____

child's reactions to visits: _____

_____

birth father's reactions to visits: _____

_____

Visits with siblings? □yes □no

frequency: _____

where are visits held? _____

child's reactions to visits: _____

_____

siblings' reactions to visits: _____

_____

Relationships with birth family

Please describe the current and past relationship with the following members:

Birth mother: _____

_____

_____

Birth father: _____

_____

_____

Siblings: _____

_____

_____

Permanency Plan *(Please describe)* _____

CONSENT AND BILLING ARRANGEMENT

CONSENT:

Dr. Sheryl Frank will provide an evaluation of the following areas: (check all that apply)

☐Behavioral functioning ☐Cognitive functioning ☐Emotional functioning

☐Family relationships ☐Academic functioning

The evaluation will consist of formal tests, child interview, and parent interview. As part of the evaluation process, Dr. Frank may obtain information from the following sources: (include name and phone number)

School: _____

Daycare facility/babysitter: _____

DHS worker: _____

Lawyer: _____

Other: _____

Following the evaluation, you will receive verbal and written feedback within one month of the last day of testing. Please inform Dr. Frank if you need the evaluation report earlier than one month from testing.

CONFIDENTIALITY:

These results will be confidential. Reports will only be sent to additional parties with the parent's or legal guardian's consent.

In the following circumstances the results will not be confidential:

- If testimony is required by a judge for certain judicial or criminal proceedings.
- If abuse or neglect of a minor is suspected. (I will make every effort to contact the guardian before I make a report, unless I judge that there is imminent danger that someone will be harmed.)
- Emergency situations such as:
  1) If a client threatens to harm him/herself or another person.
  2) If a client is in danger due to extremely severe symptoms (e.g., severe depression, psychosis).

If there is an emergency during this evaluation and I am required to contact the authorities and/or someone close to you, such as a relative or close friend:

Emergency contact name: _____ Relationship to you_____

Phone number: _____ Address: _____

CONSENT AND BILLING ARRANGEMENT

BILLING ARRANGEMENT:

The cost of the evaluation is $2,700. This fee includes:

- Administering tests
- Conducting interviews
- Reviewing previous reports
- Compiling information from sources outside the family
- Scoring and interpreting the tests
- Writing the complete report

There is no charge for the verbal feedback.

Please choose one of the following options for billing.

1. I _____ agree to be responsible for the fees associated with these services.

   _____ _____

   Parent's/Legal Guardian's Signature Date

2. Please bill the court/CFSA/Crime Victim's Fund/Law Office/Other _____ for services.

   If the aforementioned agency does not remit payment in full for the evaluation, then

   _____will remit payment for the balance due.

   _____ _____

   Parent's/Legal Guardian's Signature Date

I have read and understand the complete Consent and Billing Arrangement.

I give Dr. Sheryl Frank permission to provide evaluation services to:

_____ _____ _____

Child's Name Parent's/Legal Guardian's Signature Date