



Discovery Program of IL, LLC

APPLICATION FOR SEARCH EVALUATION

Name of Student _____ Date _____

Birthdate _____ Age ____ Grade ____ Sex ____ Teacher _____

Father _____ Occupation _____ Work Phone _____

Mother _____ Occupation _____ Work Phone _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Referred by _____

FAMILY HISTORY

Child is living with:

- Natural father Stepfather Natural mother Stepmother
- Legal guardian Other _____

Child is: Adopted Foster

Since the child's birth there has been:

- Death in the family
- Separation
- Divorce
- Remarriage of mother
- Remarriage of father
- Other major trauma (please describe)

Reaction of child:

Other children in the family:

Name	Age	Grade	Present school
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there a history of learning difficulties in the family? Yes No

If yes, please explain: _____

Briefly describe your child's relationship with you, your spouse and other members of the family:

Religious affiliation: _____

MEDICAL/DEVELOPMENTAL HISTORY

Child was: Full Term Premature

State any complications that occurred during pregnancy (e.g., toxemia, diabetes, etc.):

State any complications that your child had immediately after birth (e.g., difficulty breathing, blue color, etc.):

Check where applicable:

- | | |
|---|---------------------|
| <input type="checkbox"/> Recent physical exam | Date /results _____ |
| <input type="checkbox"/> Recent eye exam | Date/results _____ |
| <input type="checkbox"/> Recent hearing exam | Date/results _____ |
| <input type="checkbox"/> Recent speech evaluation | Date/results _____ |

Check any problems in infancy or childhood with:

- | | | | |
|-----------------------------------|-------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Colic | <input type="checkbox"/> Talking | <input type="checkbox"/> Crawling | <input type="checkbox"/> Walking/running |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Eating | <input type="checkbox"/> General slow development |

Child: (Check where applicable)

- | | | |
|--|--|--|
| <input type="checkbox"/> Needs glasses | <input type="checkbox"/> Wears glasses | <input type="checkbox"/> Has/Had frequent ear infections |
| <input type="checkbox"/> Has allergies/ asthma | <input type="checkbox"/> Has/Had high fevers | <input type="checkbox"/> Has/Had hearing difficulties |
| <input type="checkbox"/> Has/Had seizures, convulsions or staring spells | <input type="checkbox"/> Experienced injury/accident to the head | |

Explain any items checked: _____

Is your child presently on medication? Yes No

If yes, please identify type, dosage, and explain any noticeable affects of medication on behavior:

EDUCATIONAL HISTORY

List all schools attended (Preschool to present):

School	Grades	Reason for change
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child writes with: Right hand Left hand Both hands Is a mirror writer

Check where applicable:

- Repeated grade(s); if so, grade(s) repeated _____
- Received tutoring; if so, subject(s) _____
- Enrolled in special class, if so, what kind of class(es) _____
- Receives/received speech/language therapy
- Receives/received physical/occupational therapy
- Received vocational/rehabilitational training

State child's best and worst subjects:

Best _____ Worst _____

Child has been tested before: Yes No

If yes, give date and location of testing : _____

Child has been diagnosed as: ADD ADHD Learning Disabled Other _____

Additional comments or information regarding child's schooling:

State the area(s) in which *you* feel your son/daughter needs help:

SOCIAL/BEHAVIORAL HISTORY

Check areas that apply to your son/daughter:

- | | | | |
|---|---|-------------------------------------|---|
| <input type="checkbox"/> Independent | <input type="checkbox"/> Lacks common sense | <input type="checkbox"/> Stubborn | <input type="checkbox"/> Dependent |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Complains about school |
| <input type="checkbox"/> Dishonest | <input type="checkbox"/> Overly fearful | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Overly sensitive |
| <input type="checkbox"/> Shy | <input type="checkbox"/> Enjoys school | <input type="checkbox"/> Moody | <input type="checkbox"/> Self-centered |
| <input type="checkbox"/> Passive | <input type="checkbox"/> Makes friends easily | <input type="checkbox"/> Confident | <input type="checkbox"/> Easily frustrated |
| <input type="checkbox"/> Prefers playing with much older children | <input type="checkbox"/> Prefers playing with much younger children | | |

Is there any additional information you would like to personally share with the Discovery Program Director prior to testing? Yes No

FEES FOR TESTING

The Discovery Program of IL, LLC would be pleased to arrange a SEARCH SCREENING for your child. A check in the amount of \$50.00 made payable to Discovery Program of IL, LLC must accompany this application.

Parent's signature

Date