



Discovery Program of IL, LLC

APPLICATION FOR 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 _____ Cell phone _____ E-mail address _____
 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

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

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

PERMISSION FOR TESTING/REPORTING

The Discovery Program, Inc. would be pleased to arrange a psycho-educational assessment for your child. If you choose this option, a separate check for \$300 payable to Discovery Program of IL, LLC. must accompany this application.

- We give permission for Discovery Program of IL, LLC to arrange a complete psycho-educational assessment for our son/daughter.
- We choose the above option and have enclosed check for \$300.
- We give permission for Discovery Program of IL, LLC to administer NILD prescribed battery of tests and have enclosed an additional check for \$300 payable to Discovery Program of IL, LLC.
- I give Discovery Program of IL, LLC permission to share testing results with my child's school.

Parent's signature

Date