ASSESSMENT AND COUNSELING CLINIC
The Connie Belin & Jacqueline N. Blank International
Center for Gifted Education and Talent Development

Please complete form electronically and return to bbc-clinic@uiowa.edu. You may need to open Adobe Acrobat Reader (https://acrobat.adobe.com/us/en/products/pdf-reader.html) **to save.**

BACKGROUND INFORMATION

FAMILY AND SCHOOL INFORMATION

Child's name:_____ **Today's date:**_____

Birthdate: _____ **Age:** _____ **Grade:** _____

Gender:

- ☐ **Male** ☐ **Other:**_____
- ☐ **Female**

Racial/ethnic/tribal affiliation (optional)

- ☐ **Alaskan Native or American Indian (tribal/nation affiliation** _____**)**
- ☐ **African-American/Black**
- ☐ **Hispanic/Latino(a)**
- ☐ **Asian or Pacific Islander**
- ☐ **White, not of Hispanic/Latino(a) origin**

How did you learn about our clinic? _____

Home Address:_____ **Phone:**_____

_____ **Phone:**_____

Person filling out this form:

- ☐ **Mother**
- ☐ **Father**
- ☐ **Other:**_____

Is the child adopted or currently in foster care?

- ☐ **Yes**
- ☐ **No**

Parent's/Guardian's name: _____ **Age** ____ **Education:** _____
Occupation: _____ **Phone: Home:** _____ **Business:** _____
Email Address:_____
Parent's/Guardian's name: _____ **Age** ____ **Education:** _____
Occupation: _____ **Phone: Home:** _____ **Business:** _____
Email Address:_____
Other parent's name: _____ **Age** _____**Education:** _____
Occupation: _____ **Phone: Home:** _____ **Business:** _____
Other parent's name: _____ **Age** _____**Education:**_____
Occupation: _____ **Phone: Home:** _____ **Business:** _____
Marital status of parents: _____
If parents are separated or divorced, how old was child when the separation occurred? _____
If parents are divorced, what are the custody arrangements? _____
_____

Insurance Provider _____ **Relationship to child** _____
Name of policy holder _____**Date of birth of policy holder** _____

List of all people living in household:

Name ***Relationship to child*** ***Age***

_____
_____
_____
_____
_____

If any brothers or sisters are living *outside* the home, list their names and ages:

Name ***Relationship to child*** ***Age***

_____
_____
_____

Primary language spoken in the home: _____

Child's primary language: _____

PRESENTING CONCERNS

Briefly describe the reason(s) that bring your child to this clinic: _____

_____
_____
_____

How long has this been a concern of yours? _____

Has the child received psychoeducational evaluation or intervention?

- ☐ **Yes**
- ☐ **No**

If yes, when and with whom? _____

_____
_____

Has the child previously participated in counseling or therapy?

- ☐ **Yes**
- ☐ **No**

If yes, when and with whom (please include provider's name and location/name of clinic)

_____
_____
_____

Recent significant family stressors: _____

EDUCATIONAL HISTORY

School Name: _____

School Address: _____ **Phone:**_____

_____ **Teacher:** _____

Did your child attend preschool or daycare?

- ☐ **Yes**
- ☐ **No**

ACADEMIC ACCELERATION

Has your child completed above-level testing?

- ☐ **Yes**
- ☐ **No**

If yes, please indicate where testing was completed (attach results if possible) _____

Has your child been accelerated a grade?

- ☐ **Yes**
- ☐ **No**

If yes, which grade: _____

Has your child adjusted well to the acceleration?

- ☐ **Yes**
- ☐ **No**

If no, please explain: _____

Has your child been accelerated in a subject?

- ☐ **Yes**
- ☐ **No**

If yes, which subject(s): _____

Has your child adjusted well to the subject acceleration?

- ☐ **Yes**
- ☐ **No**

If no, please explain: _____

Has your child participated in a talented and gifted program?

- ☐ **Yes**
- ☐ **No**

ACADEMIC CONCERNS

Place a check next to any educational concern that your child currently exhibits.

- ☐ **Has difficulty with reading**
- ☐ **Has difficulty with math**
- ☐ **Has difficulty with spelling**
- ☐ **Has difficulty with writing**
- ☐ **Does not like school**
- ☐ **Has difficulty with other subjects (please list)** _____

Has your child received special tutoring or therapy in school?

- ☐ **Yes**
- ☐ **No**

If yes, please describe: _____

Has your child ever been retained a grade?

- ☐ **Yes**
- ☐ **No**

If yes, which grade _____

Does your child have a 504 Plan?

- ☐ **Yes**
- ☐ **No**

Does your child have an Individualized Education Program (IEP)?

- ☐ **Yes**
- ☐ **No**

If your child has a 504 Plan or IEP, please attach a copy.

DEVELOPMENTAL AND BEHAVIORAL CONCERNS

Place a checkmark next to any behavior or problem that your child currently exhibits (within the past 6 months) or has exhibited in the past.

Concern	*Current*	*Past*
Cannot play quietly	☐	☐
Impulsive	☐	☐
Hard time waiting turn	☐	☐
Interrupts	☐	☐
Attention problems	☐	☐
Problems following directions	☐	☐
Disorganized/forgetful	☐	☐
School refusal	☐	☐
Aggressive behavior	☐	☐
Problems relating with peers	☐	☐
Tearful	☐	☐
Irritable	☐	☐
Change in appetite/weight	☐	☐
Problems with concentration	☐	☐
Recurrent thoughts of death	☐	☐
Suicidal thoughts	☐	☐
Sleep changes	☐	☐

Concern	*Current*	*Past*
Night terrors/nightmares	☐	☐
Frequent worrying	☐	☐
Separation problems	☐	☐
Phobias/fears	☐	☐
Panic attacks	☐	☐
Obsessions/Compulsions	☐	☐
Complaints of pain/illness	☐	☐
Tics	☐	☐
Seizures	☐	☐
Eating disorder	☐	☐
Hallucinations	☐	☐
Delusional thinking	☐	☐
Substance use or abuse	☐	☐
Trouble with the law	☐	☐
History of abuse or trauma	☐	☐
Other areas of concern	☐	☐

If yes, please explain _____

EARLY DEVELOPMENTAL HISTORY

Were there any pregnancy complications?

- ☐ **Yes**
- ☐ **No**

If yes, explain _____

Was the child premature?

- ☐ **Yes**
- ☐ **No**

If so, by how many weeks? _____

Were there any birth defects or complications?

- ☐ **Yes**
- ☐ **No**

If yes, please describe: _____

What was the child's condition at birth? _____

Were there problems in growth or development during the first few years?

- ☐ **Yes**
- ☐ **No**

If yes, please describe: _____

Please indicate the age at which your child first demonstrated each of these behaviors.

Behavior	Age	Behavior	Age
Walked alone	_____	Toilet trained (daytime)	_____
Spoke first word	_____	Stayed dry at night	_____
Put several words together	_____	Began to read	_____
Rode tricycle	_____	Began to count	_____

Did you have any concerns about your child's early development?

- ☐ **Yes**
- ☐ **No**

If yes, please specify: _____

MEDICAL HISTORY

Child's primary medical provider: _____ **Phone:**_____

Clinic Name and Location: _____

List current medical and/or psychological diagnoses ***Age at diagnosis***

_____
_____
_____
_____

Please indicate if your child has experienced any of the following:

Condition	Date or Age	Cause/Reason
☐ Head Injury	_____	_____
☐ Broken bones	_____	_____
☐ Hospitalization	_____	_____
☐ Operations	_____	_____

List current medications/dosage ***Condition prescribed to treat*** ***Prescribing provider***

_____
_____
_____
_____

Please list other professionals currently providing care for your child (e.g., medical provider, speech therapist, occupational therapist, etc.) and the name of the clinic/agency where provided:

_____
_____
_____

When was your child's most recent hearing screen/evaluation? _____

What were the results? _____

Does your child wear a hearing aid?

- ☐ **Yes**
- ☐ **No**

When was your child's most recent vision screen/evaluation? _____

What were the results? _____

Does your child wear glasses or contact lenses?

- ☐ **Yes**
- ☐ **No**

FAMILY MEDICAL HISTORY

Family psychological/psychiatric history, including learning or attention difficulties?

_____

_____

_____

ADDITIONAL INFORMATION

What are your child's favorite activities? _____

_____

What activities does your child like the least? _____

_____

Please list any extracurricular activities in which your child is currently involved: _____

_____

What are the primary disciplinary or behavioral management strategies you use at home (e.g., time out, reward system, ignoring, reasoning, etc.)? _____

_____

What have you found to be the most satisfactory ways of helping your child? _____

_____

What are your child's strengths? _____

_____

_____

Is there any other information that you think may help us in working with your child?

_____

_____

_____

_____

Additional Comments