Assessment & Intervention Services of Richmond, LLC

REFERRAL QUESTIONNAIRE

Identifying Information

Child's Name_____ Date of Birth_____

School _____ Age _____ Grade_____

Name of Parent(s)_____

Address_____

_____

Phone Number(s)_____/_____

Email_____

Language(s) spoken in home_____

When was hearing and vision last checked? _____

Reason for Referral

_____

_____

Is there another family member with a history of learning difficulties? _____

What question(s) would you like answered from the assessment? _____

_____

_____

What are the child's strengths? _____

_____

_____

Background Information (Mark X if currently or in the past)

Complications during pregnancy? _____ Complications at birth? _____
Age of mother at birth? _____ Adopted? _____
Speech or language delays? _____ Tubes in ears? _____ Speech therapy? _____
Gross motor delay? ____ Unusual gait? _____ OT/PT? _____
Fine motor delay? ____ Tactile sensitivity? _____ Picky eating habits? _____
Hearing problem? ____ Auditory difficulties? _____
Vision problem? _____ Glasses?____
Sleep difficulties? _____ Sleep apnea? _____
Eating difficulties? _____ Overweight? _____ Underweight? _____
Toileting difficulties? _____ Toileting accidents? _____
Hospitalizations? _____ ER visits? _____ High fever?_____ Surgeries? _____
Chronic health problem? _____ Allergies? _____ Asthma? _____
Currently taking medication? _____ Please List: _____
Head Injury? _____ Loss of consciousness? _____ Concussion? _____
Seizures? _____ Tics?_____
Attention problems? _____ Hyperactivity? ____ Disorganized?_____ Impulsive?_____
Accidental or lead poisoning? ____
Vehicle accident? _____
Broken bones? ____
Poor social skills? _____ Prefers to play alone? _____ Difficulty with change? _____
Rigid patterns of behavior? _____ Restricted interests? _____
Emotional Trauma? _____ Changes in family? _____ Significant Loss/Grief? _____
Abuse/Neglect? _____ Domestic violence? _____
Psychiatric/psychological treatment? _____ Out of touch with reality? _____
Aggressive? _____ Cruel or threatening? ____ Stealing? ____ Playing with fire? ____
Anger outbursts? _____ Easily irritated? _____ Argumentative? _____ Defiant? _____
Anxiety/nervousness? _____ Obsessive/compulsive? _____
Sadness/depression? _____ Low self-esteem? _____ Withdrawn? _____
Suicidal thoughts/attempts? _____ Cutting/self-harming? _____
Repeated grade/retained in grade? _____ Special Education/504 plan? _____
Reading problem? _____
Math problem? ____
Writing problem? _____
School suspension/expulsion? ____ Excessive school absences? _____
Juvenile court involvement? _____ Probation? _____
Alcohol or drug use? _____ Other concern? _____

Please list any strategies you have already tried for the referral concern?