SCHOOL INFORMATION:

Name:

Address:

Phone Number: **Fax Number:**

School Grade Level:

Teacher's Name:

ACADEMIC HISTORY:

Academic History	Yes	No	Unsure	If Yes,
Currently performing functioning below grade level				Years below grade level
Has psychological testing for academic learning problems be given				List and attach testing completed

CURRENT CONCERNS:

Concern	Check off current specific signs and symptoms that apply	How long has the client had these symptoms (months-years)
Anxiety	__Phobias __Nightmares __Obsessive Compulsive __ Somatic Complaints	
Depression		

Bipolar Mood Disorder		
Psychotic Disorder		
Attention-Concentration		
Autism, Asperger's, Pervasive Developmental Delay		
Behaviour		
Social		

Substance(s) Used		

Is there a history of any of the following	**Yes**	**No**	**Unsure**
Developmental handicap			
Head Injury with Loss of Consciousness			
Violent Behaviour			
Suicidal Attempts			
Self Harming Behaviour			
Legal Involvement			
Hospitalizations			

Past-Present Medications (Psychotropic and non-psychotropic):

Medication	**Dose Frequency**	**Comments**
		Past Present

LIST OF OTHER SERVICE PROVIDERS PRESENTLY INVOLVEMENT (MCFD, COMMUNITY AGENCIES, ETC.)

NAME	**DURATION**	**OUTCOME COMMENTS**