Welcome to Playa Vista Mental Health

We look forward to working with your family.

Please fill out this form as best you can. Having all the facts will help us do the most thorough evaluation and be most helpful to you. If you can't remember something exactly, put an approximate answer with a question mark. Please feel free to use the backs of the pages for extended answers.
STUDENT INFORMATION

Student Name: ____________________________________________

School: ___________________________________________________

Grade: ____________________________________________________

Date of Birth: _____________________________________________

Age: _________________________________________________________________________________

Parent / Guardian 1 Name: ______________________________________

   Email: ______________________________________________________

   Cell Phone: __________________________________________________

   Primary Address: _____________________________________________

   _________________________

   _________________________

   Billing Address, if different: _________________________________

   _________________________

   _________________________

Parent / Guardian 2 Name: ______________________________________

   Email: ______________________________________________________

   Cell Phone: __________________________________________________

Name of the person completing this form: _____________________________

Relationship to the child: __________________________________________

Who were you referred by: __________________________________________
What specific questions do you hope to have answered by this evaluation/consultation and/or treatment?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Describe any recent medical, academic, or other events that led to this assessment.

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

What are your concerns about your child? What do you think may be causing the difficulties you are concerned about?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

What interventions have you tried in the past to help with these areas of difficulty (e.g. tutoring, counseling, speech therapy, occupational therapy, behavior management programs, etc.)?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

What do you consider to be this child’s greatest:
A. Strength:
_______________________________________________________________________
_______________________________________________________________________

B. Challenge:
_______________________________________________________________________
_______________________________________________________________________

What school subjects are the easiest for your child? ____________________________

What school subjects are the hardest for your child? ____________________________

What are your child’s current grades? Please attach a copy of the last report card, if possible.

Has the child already been given any diagnoses? □ Yes □ No
   If yes, what are they? ________________________________________________
   By whom, and when? ________________________________________________

Does the child's sibling(s), parents or other family member have a diagnosis? □ Yes □ No
   If yes, what is it/are they?

Has this child already had testing/evaluations/504 Plan/IEP? If yes, what were the results and conclusions? (Please include copies of relevant reports and IEPs.)
MEDICAL HISTORY

Pediatrician's name and phone number: 

__________________________________________

When was your child's last visit with the pediatrician? ________________________________

☐ Please list any problems or medical diagnoses: ________________________________

__________________________________________

☐ Medications (Please list all current medications. Specify type, dosage and for treatment of what condition)

__________________________________________

__________________________________________

Is your child right or left handed? ______________________________________

When was your child’s last vision evaluation: ________________________________

  Does your child wear glasses?   Yes   No   Since what age? ____________

  Does your child wear contacts?   Yes   No   Since what age? ____________

  If so does s/he wears them all of the time or only under specific circumstances (e.g., for reading) ________________________________

When was the last hearing exam? ________________________________

  Does the child wear hearing aids (If so, since what age?): __________________________

Do you have any concerns about this child’s eating habits, diet, nutrition, or growth? ☐ Yes ☐ No

  If yes please describe:

_______________________________________________________________________________

_______________________________________________________________________________
Has your child ever been in counseling or therapy? Please describe any previous counseling—reasons for treatment, length of treatment, therapist name, type of treatment (e.g., family, individual, group therapy).

DEVELOPMENTAL HISTORY

Briefly, what was the child like to care for as an infant?

Did the child achieve motor milestones on time? □ Yes □ No
At what age did he/she start crawling? _________ months.
First walk? ______________________ months
Do you have any concerns about the child's strength and coordination?
 □ Yes □ No
If yes, please describe. ______________________

Did the child achieve language milestones on time? □ Yes □ No
At what age did the child say his/her first words? ______________________
What was the child's first word? ______________________
At what age did the child say his/her first sentence? ______________________
Does the child speak clearly? □ Yes □ No
If no, what sounds are hard to say? ______________________
Does the child have trouble picking up on nonverbal cues such as gestures or humor?

☐ Yes  ☐ No

Please describe any other concerns you have about your child's language development.  
__________________________________________________________________________
__________________________________________________________________________

Does your child get regular exercise? __________________________________________

If so, how often? What type? __________________________________________

Sleep related issues:
How many hours per night does your child sleep? ________________________

FAMILY/SOCIAL HISTORY

Was the child adopted?  ☐ Yes  ☐ No
If yes, from where? __________________________________________

Are the child's parents  ☐ married  divorced since ________________________
☐ single  separated since ________________________
other __________________________________________

If the parents are not together, what is the custody agreement?
__________________________________________________________________________

Information regarding biological parents:
Name/ Age/ Occupation Mother:
__________________________________________________________________________
Name/ Age/ Occupation Father:
____________________________________________________________________________

Please indicate any health problems of the parents. If deceased, please indicate age/cause of death.
____________________________________________________________________________

What is the child's first language? Are any other languages spoken at home?
____________________________________________________________________________

Please list who lives in the home with this child (parents, siblings (age/grade), grandparents, etc.):
1. ____________________________________________________________
2. ____________________________________________________________
3. ____________________________________________________________
4. ____________________________________________________________
5. ____________________________________________________________
6. ____________________________________________________________
7. ____________________________________________________________
8. ____________________________________________________________

Does the child now or in the past share a room someone else? With whom? At what age?
____________________________________________________________________________

How would you characterize your child's relationship with his/her siblings?
____________________________________________________________________________

Describe history of childcare and list who currently cares for this child throughout the day:
____________________________________________________________________________

What is your child’s relationship like with you? What do you appreciate most about your child?
____________________________________________________________________________
What discipline methods have you found to be most effective with your child?
____________________________________________________________________________
____________________________________________________________________________

Does your child have any special talent/abilities?
____________________________________________________________________________

What hobbies, interests, after school activities does your child enjoy?
____________________________________________________________________________

Briefly describe the child’s socialization history.

How well does s/he relate to other children who are the same age?
____________________________________________________________________________
____________________________________________________________________________

Has this pattern changed over time? ________________________________

____________________________________________________________________________

How well does s/he relate to adults and older children?
____________________________________________________________________________

Does your child prefer

- group activities
- Individual activities
- both group and individual activities

What is your child’s general mood? Are there any patterns you notice in your child’s mood?
____________________________________________________________________________
In case of emergency, I give authorization for treatment by a qualified doctor or any person qualified to give emergency treatment. I release Playa Vista Mental Health from any liability for injury that may arise.

Parent’s signature ___________________________ Date _______________________

Persons to be contacted in case parents cannot be reached:

<table>
<thead>
<tr>
<th>Name/relation to child:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name/relation to child:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

**Emergency Information**

Physician: 

Address: 

Phone:
CONSENT FOR EVALUATION

Date: __________________________

Sole Custody:
I, ____________________________, have sole legal and physical custody
of __________________________ and the sole right to make legal and medical
decisions on his/her behalf. I authorize Playa Vista Mental Health to conduct an
educational evaluation to gather more information about how to better meet my child’s
needs.

Joint Custody:
We, ____________________________, and ________________________ --
have legal and physical custody of __________________________ and the right to
make legal and medical decisions on his/her behalf. We authorize Playa Vista Mental
Health to conduct an educational evaluation to gather more information about how to
better meet my child’s needs.

Signature: ______________________ Signature: ______________________

Witness: __________________________

CONSENT FOR RELEASE OF INFORMATION

I (We), ____________________________, and ____________________________,
authorize you to give psychoeducational information and receive educational, medical and/or
psychological information, including written records and files regarding:

______________________________ (Child’s name)

Signature: ______________________ Signature: ______________________

Witness: __________________________
Psychoeducational Evaluation Form

TERMS & CONDITIONS

Please return all forms to our front desk before leaving the office. If you require additional time to complete at home, please return to us via fax at (888) 308-0861. In order to conduct an evaluation all forms must be completed in full and signed in the appropriate places.

Child's parents and/or legal guardians acknowledge that no warranty or guarantee, express or implied, is made as to any student's success or performance on any test or in any other procedure or process designed to assess a student's intelligence, knowledge and/or academic abilities and hereby waives any such warranty or guarantee existing by operation of law. Student's parents and/or legal guardians further acknowledge that a student's failure to perform on any test or in any other procedure or process designed to assess a student's intelligence, knowledge and/or academic abilities at the level expected shall not constitute a breach of this contract nor any other legally cognizable cause of action against Playa Vista Mental Health, or any of its officers, directors, employees, independent contractors or agents. Student's parents and/or legal guardians hereby release and discharge Playa Vista Mental Health its officers, directors, employees, independent contractors and agents from any and all liability for injury and/or damages allegedly arising out of student's failure to perform at any defined level on any such test or other procedure or process designed to assess a student's intelligence, knowledge and/or academic abilities.

*IN SIGNING THIS AGREEMENT, we understand that we agreeing to the terms and conditions of this document and are undertaking the full and legal financial responsibility for promptly paying the child’s fees. We agree that if more than one person signs this agreement our obligation under its terms is joint and several. We also agree to inform Playa Vista Mental Health immediately of any changes in legal custody or of impending difficulties in payment, and to respond promptly to all communications from Playa Vista Mental Health.*

Name of Student __________________________

Signature(s) of parent(s) or person financially responsible for the student: Date: __________

__________________________________________

__________________________________________

Please print Name:  Please print Name: