



Therapist Initial Evaluation Form Children & Adolescents Only

Child's Name: _____

Developmental History (Development milestones met early, late, normal): _____

Perinatal History (Details of labor/delivery): _____

Prenatal History (Medical problems during pregnancy, mother's use of medications): _____

Parenting Style: _____

Discipline / Consequences: _____

Does your child have friends/plays well with other children: _____

Has your child been evaluated by the I.U.? YES NO What findings?: _____

Has your child been evaluated by a Developmental Pediatrician or Neurodevelopmental Doctor?

YES NO Name of Evaluator: _____

What findings?: _____