



Educational Diagnostic Center

Intake Form

Neuropsychological/Psychoeducational Evaluation

CONFIDENTIAL

Student Name _____ Today's Date _____

Date of Birth _____ Age _____

Please Check: Female _____ Male _____ Social Security # _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

School & Grade Level _____ Grade Point Average if known _____

Place of Birth _____ Religion, if applicable _____

Parents' or Guardian's Names & Occupations _____

Siblings' Names & Ages _____

Emergency Contact Name & Phone (if different from above) _____

Name of Primary Care Physician or Pediatrician _____

How did you hear about this service? Who referred you? _____

Describe below the difficulties or symptoms for which you are seeking assistance.

Has the student ever been diagnosed with a learning, reading/dyslexia, executive function, behavioral or attention disorder? If yes, please explain.

Has the student ever received academic assistance, accommodations (504 plan, IEP), tutoring, or extra help for school performance? Has the student undergone previous educational evaluations? If yes, please explain.

Has the student ever sustained a head injury, concussion, or sport-related, or motor vehicle accident. If yes, please describe and list dates.

Please list any significant past or present medical or health related conditions, treatments, injuries or surgeries. Is the student now receiving treatment for any of these conditions?

Has the student in the past, or is the student currently, participating in any mental health or psychiatric treatment or personal counseling? If yes, please list diagnoses if any, the type of treatment, approximate dates, duration of treatment, and the treatment provider.

Has the student ever been hospitalized for any condition? If yes, reason for hospitalization and approximate date.

Is there a family history of a learning, reading/dyslexia, executive function, behavioral, or attentional disorder? If yes, please describe.

Is there a family history of mental health or psychiatric difficulties or treatment? If yes, please describe.

Have there been any episodes or problems with substance use, alcohol, or cigarette smoking?

Have there been problems with the law or juvenile justice system?

Please list name and dosage of any medications the student is currently taking.

Does the student experience any allergies? Please list.

Is there anything else we should know for the purpose of this evaluation?
