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| Below is the e-report generated by your client's responses to the questionnaire on the website [patienthistoryhelper.com](http://patienthistoryhelper.com/).  This document cannot be edited within an email program, but it can be edited within any word processing application (such as Word, OpenOffice Writer, Pages, etc.).  Please highlight the text you want from this email, select the "copy" option within your program, and then "paste" it into a word processing application.  You may also use the following keyboard shortcuts:  To select all content from this email:  CTRL+A on a PC; CMD+A on a Mac. (Depending on your email program (e.g., Gmail) you may have to hit "Reply" first.) To copy all content from this email:  CTRL+C on a PC; CMD+C on a Mac. To paste all content into your Word program:  CTRL+V on a PC; CMD+V on a Mac.  You may need to edit margins to make the responses/boxes fit within the document the way you prefer.  If copying from a Mac Mail program or Safari browser, a few extra steps need to be taken to make the form fit properly into a Word document: 1.  Copy and paste the history into Word in the manner addressed above. 2.  Choose to View the Word document in "Draft." 3.  Highlight the history section you desire by clicking and dragging over it or select the entire document by holding Command + A at the same time. 4.  Place your cursor over the far right edge of a table or text until it changes to the symbol showing the vertical lines.  Client responses in black text indicate a typical response was provided, responses in blue text indicate some type of issue/difficulty with her response, and responses in green text indicate suggestions/options that you may want to address to help provide more clarity to the report.  We highly encourage you to review your client's responses, seek clarifying details from them regarding their answers, and edit this document as appropriate.  **Agreed to Terms of Use:** Yes  **Client Email Address:** [sarasmith@earthlink.net](mailto:sarasmith@earthlink.net) | |
| **QUESTIONNAIRE SUMMARY** | |
| **Client Name:** Smith, John | |
| **DOB:** 3-28-2007 | |
| **Age When Client History Completed:** 6 years 0 months 0 days | |
| **Date Client History Completed:** 3-28-2013 | |
| **Date of Assessment:** 3-29-2013 | |
| **Examiner:** James McCray, Psy.D. | |
| **Background Information:** | |
| *History form completed by* | Mrs. Sarah Smith, mother of John. |
| *Persons attending the current assessment* | Examiner: Fill in as appropriate. |
| *Parents and living situation* | Biological father: Mr. Jim Smith, 33 years old.  Biological mother: Mrs. Sarah Smith, 31 years old.  John and both parents live together full time.  Mrs. Smith indicated that no other people live within the biological parents' home. |
| *Languages spoken within the home* | Primary language used with John: English. |
| *Moves within John's lifetime* | John's family has moved twice in his life, with the most recent move occurring when he was 4 years old, which he adjusted to with great difficulty. |
| **Birth:** |  |
| *Maternal age at birth* | 25 years old. |
| *Prenatal care* | John's mother began receiving prenatal care within the second trimester. |
| *Exposure to illicit or toxic substances while pregnant* | Mrs. Smith reported John's mother "i might have had a beer and sushi before I realized I was pregnant, but neither in excess." |
| *Difficulties with pregnancy* | None reported by Mrs. Smith. |
| *Amniocentesis completed* | Not completed. |
| *Gestation* | 40 weeks (full term). |
| *Delivery* | Mrs. Smith reported that John was born by emergency cesarean section and complications included: "the labor failed to progress and fetal distress was detected and they decided to do a c-section." |
| *Birth weight and length* | 7 lb 5 oz and 19 inches long. |
| *APGAR scores* | Unknown by Mrs. Smith. |
| *Significant postnatal issues* | None reported by Mrs. Smith. |
| **Medical:** |  |
| *Overall health* | Examiner: Fill in as appropriate. |
| *Significant illnesses* | Mrs. Smith reported John had "john has had three episodes of significant vomiting. We didn't know what caused it and took him to the emergency room each time. Doctors gave him fluids through an IV and he recovered quickly." |
| *Significant injuries* | None reported by Mrs. Smith. |
| *Hospitalizations* | None reported by Mrs. Smith. |
| *Surgeries* | None reported by Mrs. Smith. |
| *Signs of seizures* | None reported by Mrs. Smith. |
| *Chronic ear infections* | John has never had an ear infection. |
| *Allergies to environment, food, or medications* | Mrs. Smith reported John is allergic to the following: "john is allergic to whole eggs but can tolerate products with eggs in it." |
| *Asthma difficulties* | Mrs. Smith indicated John has asthma "it's mild and he has an Albuterol inhaler which he only uses a few times a year." |
| *Currently or previously prescribed psychotropic medications* | None reported by Mrs. Smith. |
| *Hearing* | Mrs. Smith reported John's hearing was tested by a specialist when he was 4 years old, which indicated normal auditory functioning, and she does not have concerns about John's hearing at this time. |
| *Vision* | Mrs. Smith reported John's vision was tested by a specialist when he was 5 years old, which indicated vision difficulties, including "he was found to have a mild astigmatism, but not to the point of requiring corrective lenses," and she does not have concerns about John's vision at this time. |
| *Eating patterns* | John prefers to snack throughout the day rather than eat solid meals. |
| *Sleeping patterns* | Mrs. Smith reported John often resists or has difficulties falling asleep, which takes approximately 30 to 45 minutes.  He does not have nightmares or night terrors regularly.  John typically sleeps nine hours per night without waking.  He usually does not take naps. |
| *Pica (consuming nonnutritive substances)* | Mrs. Smith indicated John will sometimes try to eat/swallow inappropriate items, such as "john likes to eat a little bit of playdough sometimes, but not enough to upset his stomach." |
| *Diarrhea or constipation issues* | None reported by Mrs. Smith. |
| *Advanced medical tests completed in past* | None reported by Mrs. Smith. |
| *Other medical issues not addressed above* | None reported by Mrs. Smith. |
| **Development:** |  |
| *Infant temperament* | Mrs. Smith reported John was "great and quiet." |
| *Sat up without support* | 4 months of age. |
| *Crawled* | 9 months of age. |
| *Walked* | 13 months of age. |
| *Current motor skills* | Mrs. Smith does not have concerns about John's motor skills at this time. |
| *First functional words* | 12 months of age. |
| *Began combining words* | After 36 months of age. |
| *Current language skills* | Mrs. Smith believes John has a limited vocabulary for his age as he has 50 to 100 words in his expressive vocabulary at this time. He reportedly typically communicates in two- to three-word phrases. |
| *Age toilet trained* | At 4 to 4½ years of age. |
| *Periods of significant regression* | None reported by Mrs. Smith. |
| **Sensory Processing Issues and Activity Level:** Description: Sensory Processing Disorder is a neurological disorder causing difficulties with processing information from the five classic senses (vision, auditory, touch, olfaction, and taste), the sense of movement (vestibular system), and/or the positional sense (proprioception). | |
| *Auditory (sounds) issues* | Mrs. Smith reported, “He is not bothered by loud noises unless they are sudden. |
| *Visual (light) issues* | None reported by Mrs. Smith. |
| *Olfactory (smell) issues* | Mrs. Smith reported John smells items excessively/too often. |
| *Oral/Food issues* | Mrs. Smith indicated John dislikes soft food and mixed textures. |
| *Tactile (touch) issues* | Mrs. Smith reported, "he hates touching goey textures like Gack." |
| *Unusual clothes texture or fit issues* | None reported by Mrs. Smith. |
| *Vestibular (movement) issues (e.g., enjoyment of swinging, spinning, slides)* | None reported by Mrs. Smith |
| *Proprioceptive (pressure) issues* | Mrs. Smith reported John likes wedging himself between objects and leaning or pressing heavily on other people or objects. |
| *High/low pain tolerance* | Mrs. Smith reported John has an unusually high pain tolerance (he does not feel pain easily). |
| *Over- or underactive* | PN believes John has an unusually high activity level on a regular basis. |
| *Focus or attention span* | PN reported John’s attention span is very short when others are trying to get him to focus, but it is excessively strong on objects of interest to him. |
| **Education History:** |  |
| *Early intervention services (services before 3 years of age)* | Mrs. Smith reported John did not receive special services prior to 3 years of age. |
| *Day care* | According to Mrs. Smith, John started day care at 3 years of age, attending three days a week for an average of four hours per day.  John stopped attending day care at 4 years of age. |
| *Services/programs between 3 and 5 years of age* | According to Mrs. Smith, John started preschool at 4 years of age, attending four days a week for an average of 4 hours per day at Eric Jones Elementary.  John stopped attending preschool when he was 5 years of age. |
| *Kindergarten* | John began attending kindergarten at Eric Jones Elementary at 5 years of age. |
| *Elementary school* | Mrs. Smith reported John attended "Eric Jones Elementary." |
| *Current grade & school* | According to Mrs. Smith, John currently attends first grade at Eric Jones Elementary in a mainstream/regular classroom full time. |
| *Special education services* | John first qualified for special education services at 4 years of age under the primary category of Speech or Language Impaired (SLI). |
| *Behavioral difficulties* | Mrs. Smith reported, "he sometimes gets into trouble for not listening or following directions." |
| *Speech therapy* | Mrs. Smith reported John attended this service from approximately 4 years of age and is still receiving this service four times a month for 30 to 60 minutes per session. |
| *Occupational therapy* | Mrs. Smith reported John attended this service from approximately 4 years of age until 5 years of age, four times a month for 30 to 60 minutes per session. |
| *Physical therapy* | John has never been evaluated for physical therapy, according to Mrs. Smith. |
| *Autism Intervention Services* | None reported by Mrs. Smith. |
| *Developmental therapy* | John has never been evaluated for developmental therapy, according to Mrs. Smith. |
| *Other therapy programs* | None reported by Mrs. Smith. |
| *Extracurricular activities* | Mrs. Smith reported John also attends "john attended karate from 4 to 5 years of age. He has attended swimming classes every summer since 18 months of age." |
| **Behavioral & Psychological Issues:** | |
| *Visual or auditory hallucinations* | Mrs. Smith does not believe John has hallucinations. |
| *Psychiatric hospitalizations* | None reported by Mrs. Smith. |
| *Suicidal/homicidal ideation* | None reported by Mrs. Smith. |
| *History of abuse or trauma* | None reported by Mrs. Smith. |
| *Family history of learning and/or psychological disorders within the last two generations* | Mrs. Smith reported the following issues in relation to John:  Depression: maternal grandmother  Anxiety: maternal grandmother  Other disorders/issues: Mrs. Smith indicated, "Mrs. Smith was adopted and thus little is know about her family history." |
| *Attempts to hurt himself* | No significant issues reported. |
| *Attempts to hurt others* | No significant issues reported. |
| *Behavioral difficulties (e.g., tantrums)* | John typically tantrums four times a day, during which he will "throws himself on the ground, yell and kick things," which typically occurs when "not getting what he wants." |
| *Mental health services* | Never received, according to Mrs. Smith. |
| *Signs of depression* | None reported by Mrs. Smith. |
| *Signs of anxiety* | None reported by Mrs. Smith. |
| **Antecedent to Evaluation:** | |
| *Current and prior diagnosis by other professionals* | Mrs. Smith reported John has never previously been evaluated for, or diagnosed with, a psychological disorder. |
| *What led to the current assessment* | Mrs. Smith reported, "john doesn't seem to want to play with other children and he has significant language delays." |
| *Comments by Mrs. Smith on the questionnaire* | Mrs. Smith reported, "i'm really looking forward to this evaluation and figuring out what's going on!." |
| *Family's impressions* | Mrs. Smith is unclear about John's diagnosis and reported \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.  Mrs. Smith reported that she believes John has \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ based on what she has read about this disorder and/or prior assessments. |