Consultative Assessment Questionaire

Date: ______________________________

Name of Child: ______________________________

Address: ______________________________

Phone: ______________________________ Cell: ______________________________

Father: ______________________________

Mother: ______________________________

Siblings (Name, Age & Diagnosis): ______________________________

Medical History:

Child's Physician: ______________________________

Current Diagnosis: ______________________________

Diagnosing Physician: ______________________________

List Medications: ______________________________

List Supplements: ______________________________

Describe Past Medical Issues: ______________________________

-more-

Please Check if your Child Has Had Any of the Following:

Ear Infections	☐	**Gastro-intestinal Issues**	☐
Environmental Allergies	☐	**Constipation**	☐
Food Allergies	☐	**Diarrhea**	☐
Asthma	☐	**Vomiting**	☐
Eczema	☐	**Stomach Pain**	☐

Current Medical Issues/Concerns: ____________________

List Medical Tests Completed: ____________________

Referring Physician: ____________________

Is the Child on A Special Diet? ____________________

Food Likes: ____________________

Food Dislikes: ____________________

Behavior History:

What Behavioral Concerns Do You Have? ____________________

When Did the Behavior Begin? ____________________

Does the Child Engage in Repetitive Behaviors? Yes No

Please Explain: ____________________

____

____

____

____

____

____

-more-

Please Check if the Child Experiences any of the Following:

Noise Sensitivity	☐	**Tactile Defensiveness**	☐
Light Sensitivity	☐	**Sensitivity to Clothing**	☐
Aversions to Food Textures	☐	**Frequent Mouthing of Objects**	☐
Gagging/Choking	☐	**Toe Walking**	☐
Fear of Strangers	☐	**Using Peripheral Vision**	☐
No Fear of New Situations	☐	**Arm Flapping**	☐

Treatment and Therapy:

Does the Child Have an IEP or IFSP in Place? ____________________

-Please Include Most Current Copy

Are you satisfied with the Child's Services? ____________ **Yes** ______ **No** ____

Please Explain: ____________________

____

____

____

What Would You Like Your Child's Plan to Include? ____________________

____

____

____

Is the Child Undergoing other Types of Treatment, Including Medical? ____________________

____

____

____

Any Additional Comments: ____________________

____

Please Mail Assessment To: **ACT Now Nevada, 3149 Regal Oak Drive, Henderson, NV 89014**