Eve E. Wettstein, ED.S.
School Psychologist
FL License SS711

1801 North Meridian Road, Suite B
Tallahassee, FL 32303

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Office: 850-766-4426

APPLICATION FOR SERVICE

Child's Name: Date of Birth:	
Age: Gender:	
Name of School:	Grade:
Reason for Referral:	
Previous Evaluations (where and what date?):	
Is Your Child Currently Receiving Exceptional Student Education? Yes No *(if yes, please indicate what program).*	
Does Your Child Wear Glasses? Yes No *(Please indicate if corrective lenses are for distance vision or close vision)* Does Your Child Wear Hearing Aids? Yes No *(Please indicate type of hearing loss)*	
Form Completed By: *(please print)*	
Relationship to Child:	
Phone:	

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PERMISSION TO TEST AND EXCHANGE INFORMATION
(PART A)

Consent for testing and exchange of information is required of all clients or their legal guardian. Within the purview of the Florida Public Records Law (119 F.S.), I will safeguard your confidentiality. In addition, your relationship with me will not be revealed to anyone without your prior written consent. However, under certain conditions, I am legally and ethically obligated to release information about a client whether or not the client approves. These conditions include the following:

1. Suspected abuse (physical, sexual, or neglect) of children, the aged, and the disabled: As a licensed school psychologist, I am required by law to report suspected abuse to the Florida Department of Children and Families.
2. Potential homicide or suicide: In instances where a client threatens homicide, I may have to notify the intended victim and police. Likewise, if a client is thought to be at risk for suicide, family and/or authorities will need to be notified in order to protect the individual.
3. Court-orders: I must release a client's records if a judge issues a court order compelling me to do so.

Payment for this evaluation is due on the day of the evaluation. You may pay by credit card or by check or money order, payable to Eve E. Wettstein, or exact amount in cash. You may also pay via Venmo **(please be aware that Venmo is not compliant with health information privacy laws and Venmo may share information about payment for their health care with others)**.

_____ By initialing here, I certify that I have read and understand the above information and its relevance to my child's referral.

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RE:

_____

Child's Name

PERMISSION TO TEST AND EXCHANGE INFORMATION
(PART B)

As part of the evaluation process, it may be necessary to speak with and/or exchange information with school personnel, medical professionals, local or state agencies, or individuals who have served your child.

Please list below those individuals or groups with whom I may request and/or exchange information concerning your child.

1.
2.
3.
4.

By signing below, you indicate that you are the legal guardian of the referred child, that you have read and understand the information of Part A of this information, that you give permission to exchange information with the listed schools/agencies/individuals, and that you grant me permission to evaluate your child.

Signature of Parent or Legal Guardian:		Date:
Print Name:		
Relationship to Minor Child:		Email Address:
Daytime Phone:	Home:	Cell Phone:
Mailing Address:		
City:	State:	Zip:

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Child's Name:		Date:
Date of Birth:	Grade:	
School:		
Person Completing This Form:		
Relationship To Child:		

I. <u>LIST THE PROBLEMS YOUR CHILD IS CURRENTLY EXHIBITING</u> (Both academically and behaviorally):

_____

_____

_____

_____

_____

_____

_____

II. **<u>FAMILY HISTORY:</u>**

A) Family Composition:

<u>Name</u>	<u>Relationship</u>	<u>Age</u>	<u>Education</u>	<u>Employment</u>

_____

_____

_____

_____

_____

_____

_____

_____

B) Parents' Marital History:

_____

_____

_____

II. EDUCATIONAL HISTORY

A) Specific School History ***(For each grade the child has been in, list school attended, difficulties noted by parents and teachers, grades, standardized test scores, strengths, special classes or tutoring attended, behavior problems, etc.) Use back and/or separate sheet of paper if necessary.***

ELEMENTARY

Kindergarten:_____

_____

First:_____

_____

Second:_____

_____

Third:_____

_____

Fourth:_____

_____

Fifth:_____

_____

MIDDLE SCHOOL

Sixth:_____

_____

Seventh:_____

_____

Eighth:_____

_____

HIGH SCHOOL

Ninth:_____

_____

Tenth:_____

_____

Eleventh:_____

_____

Twelfth:_____

_____

_____

B) Previous psychological evaluations (Give testing dates, by whom, results and recommendations. **Please attach copies of any reports:** _____

_____

_____

_____

C) Previous counseling or therapy (Give counseling dates, by whom, results and recommendations. **Please attach copies of any reports.**): _____

_____

_____

_____

_____

III. CLIENT'S DEVELOPMENTAL /HEALTH HISTORY:

A) Pregnancy and Birth History:			C O M ME N T S
Adopted	**Y**	**N**	Age at adoption_____
Planned	**Y**	**N**	_____
High Blood Pressure/Swelling	**Y**	**N**	_____
Seizures	**Y**	**N**	_____
Morning Sickness	**Y**	**N**	_____
Excess Weight Gain	**Y**	**N**	_____
Bleeding	**Y**	**N**	_____
Infection(s)	**Y**	**N**	_____
HIV	**Y**	**N**	_____
Cigarettes	**Y**	**N**	_____
Alcohol	**Y**	**N**	_____
Prescribed Medications	**Y**	**N**	_____
Other Drugs	**Y**	**N**	_____

OTHER COMMENTS: _____

_____

_____

Labor**:**			
Full Term	**Y**	**N**	_____
Premature	**Y**	**N**	_____
Induced	**Y**	**N**	_____

OTHER COMMENTS: _____

_____

_____

Delivery:

Vaginal **Y** **N** _____

Cesarean **Y** **N** _____

Forceps **Y** **N** _____

OTHER COMMENTS:_____

_____

B) Child's Birth weight: _____

C) Birth

Complications/Treatment:_____

_____

_____

D) Developmental History (fill in all the dates you can remember):

1) Infant Health and Temperament During the First 12 Months

Difficult to feed	Y	N_____
Difficult to get to sleep	Y	N_____
Colicky	Y	N_____
Difficult to put on a schedule	Y	N_____
Alert	Y	N_____
Cheerful	Y	N_____
Affectionate	Y	N_____
Sociable	Y	N_____
Easy to comfort	Y	N_____
Difficult to keep busy	Y	N_____
Overactive, in constant motion	Y	N_____
Very stubborn, challenging	Y	N_____

2) Milestones/ages attained:

Turned over _____ Sat Alone _____

Crawled _____ Walked Assisted _____

Walked Alone _____ First Sounds _____

First Words_____ Simple Sentences_____

Potty Trained _____

COMMENTS: _____

_____

3) Developmental Delays: _____

_____

_____

_____

E) Childhood Difficulties (when, how often, treatment & last episode):

Frequent/excessive bedwetting or daytime toileting accidents_____

_____

_____

_____

Eating Patterns:

Breast Fed: _____ Formula/Type: _____

Age Weaned: _____

Past Appetite:_____

Present Appetite: _____

COMMENTS: _____

_____

_____

Sleeping Patterns (nightmares, sleepwalking, difficult time falling asleep, etc.):

Past:_____

Present: _____

Bedtime? _____Wake up time? _____ Sleeps alone? _____ Ever with parents? _____ siblings? _____

Age and how often: _____

COMMENTS: _____

_____

_____

Unusual Sensory Interests or Sensitivities? (sights, sounds, smells, tastes)

Past:_____

_____

_____

Present:_____

_____

_____

G) Medical History (Ages, treatment, last occurrence):

Illnesses(fevers, ear infections, seizures, childhood illnesses, etc.): _____

_____

_____

_____

_____

_____

_____

_____

Accidental Injuries (Age, injury, how, medical attention- where and by whom):

Hospitalizations (age, why, where, and length of stay):

Medications (age, type, dosage, when discontinued):
Past:

Present:

Physician(s) (Pediatrician, Family Practitioner, Psychiatrist, Neurologist, etc., date of last visit):

Speech, hearing, vision evaluations (include school screenings, with dates, place, results, treatment and/or recommendations):

Family Physical/Mental Health History:

Other Community Agencies Involved (e.g., CMS, TPF, DCF, DS, UCP), Mental Health Providers, etc. Give dates, services received and outcome):

_____

_____

_____

_____

_____

_____

_____

IV. <u>RELATING TO OTHERS:</u>

A) Interpersonal Relationships (quality of relationships and how problem behaviors affect relationships):

Mother:_____

_____

Father : _____

_____

Siblings: _____

_____

_____

Peers: _____

_____

_____

Significant Others: (grandparents, aunts and uncles, etc.)_____

_____

_____

B) Client's Interests/Play Activities: _____

_____

_____

_____

C) Organizations the Child Participates in (church, school, dance, music, arts, sports, civic, etc.):

Past:_____

_____

_____

Present:_____

_____

_____

D) Family Activities:

_____

_____

_____

V. <u>BEHAVIOR PROBLEMS:</u>

A) Specific Behavior Problems COMMENTS

Easily distracted	**Y**	**N**_____
Overly active	**Y**	**N**_____
Demanding	**Y**	**N**_____
Daydreams	**Y**	**N**_____
Easily frustrated	**Y**	**N**_____
Quick to anger	**Y**	**N**_____
Fighting	**Y**	**N**_____
Truancy	**Y**	**N**_____
Suspensions	**Y**	**N**_____
Vocal noise	**Y**	**N**_____
Body tics, twitches	**Y**	**N**_____
Setting Fires	**Y**	**N**_____
Fears/Phobias	**Y**	**N**_____
Obsessions	**Y**	**N**_____
Cruelty to animals	**Y**	**N**_____
Judicial involvement	**Y**	**N**_____

B) Describe your Child's Personality: _____

_____

_____

_____

C) How well does your child follow directions? Can s/he follow more than a 1 or 2-ste set of directions? _____

_____

_____

_____

D) When your child is mad/frustrated/upset, how long does it take him/her to calm and down s/he calm her/himself down or do you have to do something? _____

_____

_____

_____

E) Behavior Management Techniques (Identify main disciplinarian, methods, how often, results):

_____

_____

_____

_____

_____

*(F) OTHER COMMENTS:*_____

_____

_____

VI. <u>INCIDENCE OF NEGLECT, PHYSICAL, EMOTIONAL, AND/OR SEXUAL ABUSE</u> (when, what happened, by whom, reported/unreported, outcome):

_____

_____

_____

_____

_____

_____

_____

_____

_____

VII. <u>OTHER INFORMATION YOU THINK WOULD BE HELPFUL FOR US TO CONSIDER</u>:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Adapted from FSU Multidisciplinary Center, Social/Developmental History Report Form

Rev 7/1/2022