Dr. Teresa A. Langford, Ed.D.
Comprehensive Evaluation & Consultation, L.L.C.
4545 Bissonnet, Suite 250
Bellaire, TX 77401
832-758-0186
tereaslangford@att.net
teresa.langford10@gmail.com

Child History

IDENTIFYING INFORMATION

Your Child's Name: Date: / /

Sex: Date of Birth / /

Grade:

Parent (Father) **Occupation**

Phone - - X **Cell** - - **E-mail**

Parent (Mother) **Occupation**

Phone - - X **Cell** - - X **E-mail**

Your child lives with

Parent Address **City** **ZIP**

Referred by:

Address of Referral Source?

IDENTIFICATION OF SCHOOL PROGRESS

Do you feel that your child is experiencing problems in school? Explanation of Problem:

Chief Concern(s)

___Reading (Single Words)
___Reading Comprehension
___Spelling
___Math Calculation
___Math Word Problems
___Losing Place, Skipping Lines When Reading
___Motivation/Behavior
___Attention/ Concentration
___Seems Easily Distracted
___Forgetting To Do or Return Assignments
___Passive or Withdrawn
___Directional Problems or Hand Preference
___Phonics Skills
___Phonological Awareness
___Independent Behavior Skills
___Writing Letters, Words, or Paragraphs
___Note Taking
___ Timed Tests
___ Organizing Study Time
___ Overly Active

___Discriminating Sounds
___Speech and Language
___Working Too Hard on School Work
___Slow Work
___Reversal of Letters or Words (Reading)
___Copying from the Board or Text
___Low Self-Esteem
___Reversals of Words (Writing)
___Remembering and Following Directions
___Organizational Skills
___Seems Easily Frustrated by School Work
___Limited Recall
___Retelling Stories
___Recalling Words Easily When Speaking
___Making and Keeping Friends
___ Reversal of Letters (Writing)
___ Incomplete Assignments/Lack of Time
___ Failing Exams
___ Forgetting Information
___ Under Activity, Lethargy

LANGUAGE

Language Spoken at School [ ] Language Spoken at Home [ ]

Describe any listening or expressive language difficulties suspected:

HEALTH HISTORY

Child's Doctor (Pediatrician)

Address:

List others who have seen the child, such as Ear, Nose and Throat Dr., etc.

Neurologist: **Psychologist:**

Ophthalmologist: **Optometrist:**

ENT: **Other:**

Please list any illnesses, injuries, accidents, high fevers, or surgeries.

Type	Age	Severity of Condition	Treatment	Fever	Complications

Has your child's hearing ever been tested? Yes No

When?

By whom?

Hearing Test Results:

Does your child wear a hearing aid? **If yes, for how long?**

If hearing has not been tested, is there any reason to believe your child might have a hearing problem? Please describe.

Vision

Have your child's eyes been examined? Yes No

When?

By whom?

Results:

Does your child wear glasses? Yes No

If not, is there any evidence of a visual problem? Please describe.

Does your child have any allergies? Yes No

List and describe treatment, reactions, and severity:

Allergy to What	Reactions	Severity

Current Medications:

Name	Dosage	Length of time taken

Please describe your child's current health:

EDUCATIONAL HISTORY

Schools Attended

Name of School	Public/Private	School District	Grade(s) Attended

Grades Repeated or Skipped

Special Help Previously Received:

Special Testing Previously Completed:

Date	Type	Comments

Describe the Gifted and Talented abilities you see in your child:

SCHOOL GRADES
(Enter grades or attach copy of Report Card)

Present School Year **Year:**

Subject	1st Reporting	2nd Reporting	3rd Reporting	4th Reporting	Final Grade

Insert grades for previous year if grades have not been reported for the current school year

Year:

Subject	1st Reporting	2nd Reporting	3rd Reporting	4th Reporting	Final Grade

My child's grades :

- **Have become higher each year**
- **Have stayed about the same each year**
- **Have become lower each year**
- **Dropped suddenly in grade**

OTHER INFORMATION

Describe any other important information about your child.

Describe what you would like to learn from this evaluation:

Parent Signature: **Date** / /

*****Please attach some of your child's school work with this packet.**

Thank you for completing this Case History.
Your information is an important part of the Comprehensive Evaluation process.
All information is private and confidential.

TERESA A. LANGFORD, Ed.D.
COMPREHENSIVE EVALUATION & CONSULTATION, L.L.C.

Office: 832-758-0186
Fax: 713-218-7593
Office Locations in Bellaire and Sugar Land, Texas

4545 Bissonnet, Suite 250
Bellaire, TX 77401

13313 SW FWY, Suite 108
Sugar Land, TX 77478

www.houstontest.com
teresalangford@att.net
teresa.langford10@gmail.com

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