

**Dr. Teresa A. Langford, Ed.D.**  
**Comprehensive Evaluation & Consultation, L.L.C.**

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**Student or Adult History**

**IDENTIFYING INFORMATION**

**Name:**

**Date :**

**Sex:**

**Date of Birth**

**Grade:**

**Parent (Father)**

**Occupation**

**Phone**

**Cell**

**E-mail**

**Parent (Mother)**

**Occupation**

**Phone**

**Cell**

**E-mail**

**Parent Address**

**City**

**ZIP**

**Student Address**

**City**

**ZIP**

**Referred by:**

**Address of Referral Source?**

**IDENTIFICATION OF SCHOOL PROGRESS**

**Do you feel that you are experiencing problems in school? Explanation of Problem:**

**Chief Concern(s)**

- |  |   |
|--|---|
| <input type="checkbox"/> Reading (Single Words)                    | <input type="checkbox"/> Discriminating Sounds                  |
| <input type="checkbox"/> Reading Comprehension                     | <input type="checkbox"/> Speech and Language                    |
| <input type="checkbox"/> Spelling                                  | <input type="checkbox"/> Working Too Hard on School Work        |
| <input type="checkbox"/> Math Calculation                          | <input type="checkbox"/> Slow Work                              |
| <input type="checkbox"/> Math Word Problems                        | <input type="checkbox"/> Reversal of Letters or Words (Reading) |
| <input type="checkbox"/> Losing Place, Skipping Lines When Reading | <input type="checkbox"/> Copying from the Board or Text         |
| <input type="checkbox"/> Motivation/Behavior                       | <input type="checkbox"/> Low Self-Esteem                        |
| <input type="checkbox"/> Attention/ Concentration                  | <input type="checkbox"/> Reversals of Words (Writing)           |
| <input type="checkbox"/> Seems Easily Distracted                   | <input type="checkbox"/> Remembering and Following Directions   |
| <input type="checkbox"/> Forgetting To Do or Return Assignments    | <input type="checkbox"/> Organizational Skills                  |
| <input type="checkbox"/> Passive or Withdrawn                      | <input type="checkbox"/> Seems Easily Frustrated by School Work |
| <input type="checkbox"/> Directional Problems or Hand Preference   | <input type="checkbox"/> Limited Recall                         |
| <input type="checkbox"/> Phonics Skills                            | <input type="checkbox"/> Retelling Stories                      |
| <input type="checkbox"/> Phonological Awareness                    | <input type="checkbox"/> Recalling Words Easily When Speaking   |
| <input type="checkbox"/> Independent Behavior Skills               | <input type="checkbox"/> Making and Keeping Friends             |
| <input type="checkbox"/> Writing Letters, Words, or Paragraphs     | <input type="checkbox"/> Reversal of Letters (Writing)          |
| <input type="checkbox"/> Note Taking                               | <input type="checkbox"/> Incomplete Assignments/Lack of Time    |
| <input type="checkbox"/> Timed Tests                               | <input type="checkbox"/> Failing Exams                          |
| <input type="checkbox"/> Organizing Study Time                     | <input type="checkbox"/> Forgetting Information                 |
| <input type="checkbox"/> Overly Active                             | <input type="checkbox"/> Under Activity, Lethargy               |

**LANGUAGE**

Language Spoken at School

Language Spoken at Home

Describe any listening or expressive language difficulties suspected:

**HEALTH HISTORY**

Physician

Address:

List others you have seen, such as Ear, Nose and Throat Dr., etc.

Neurologist:

Psychologist:

Ophthalmologist:

Optometrist:

ENT:

Other:

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

<u>Type</u>	<u>Age</u>	<u>Severity of Condition</u>	<u>Treatment</u>	<u>Fever</u>	<u>Complications</u>
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Has your Hearing ever been tested?

When?

Month

Day

Year

By whom?

Hearing Test Results:

Do you wear a hearing aid?

for how long?

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

**Vision**

**Have your eyes been examined?**

Yes	No
-----	----

**When?**

**By whom?**

**Results:**

**Do you wear prescription glasses?**

Yes	No
-----	----

**If not, is there any evidence of a visual problem?**

**Do you have any allergies?**

Yes	No
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**List and describe treatment, reactions, and severity:**

<b>Allergy to What</b>	<b>Reactions</b>	<b>Severity</b>

**Current Medications:**

<u>Name</u>	<u>Dosage</u>	<u>Length of time taken</u>

**Please describe your current health:**

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**EDUCATIONAL HISTORY**

**Schools Attended**

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

**Grades Repeated or Skipped**

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**Special Help Previously Received:**

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**Special Testing Previously Completed:**

Date	Type	Comments

**Describe the Gifted and Talented abilities you see in yourself, or others have described about you.**

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**SCHOOL GRADES** (Enter current grades. Attach copy of report card or Transcript)

**Present School Year** Year:

Subject	1 <sup>st</sup> Reporting	2 <sup>nd</sup> Reporting	3 <sup>rd</sup> Reporting	4 <sup>th</sup> Reporting	Final Grade

**Insert grades for previous year if grades have not been reported for the current school year and attach report card or Transcript.**

**Year:**

Subject	1 <sup>st</sup> Reporting	2 <sup>nd</sup> Reporting	3 <sup>rd</sup> Reporting	4 <sup>th</sup> Reporting	Final Grade

**My 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 yourself**

**Describe what you would like to learn from this evaluation, and if you would like to apply for Accommodations for your Classes:**

<input type="checkbox"/> Intellectual Evaluation (IQ) <input type="checkbox"/> Academic Achievement <input type="checkbox"/> Myers-Briggs Personality Type <input type="checkbox"/> Attention Deficit and Memory	<input type="checkbox"/> Visual and Auditory Processing <input type="checkbox"/> College Accommodations <input type="checkbox"/> Learning Style <input type="checkbox"/> Gifted and Talented Creativity
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**Adult or Parent Signature:**

/ /

**\*\*\*Please bring some of your class work and tests to the evaluation.**

**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.  
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