SPENCER H. GELERNTER P.H. D.
& ASSOCIATES

CHILD * ADULT * FAMILY * COUPLES

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JATP INFORMATION FORM

Date:_____ Referred By:_____

Child's Name: _____Home Phone: _____
Address:_____ Date of Birth:_____ Age:_____
City:_____ State:_____ Zip:_____ Religion:_____
School:_____ Grade:_____ Teacher:_____

List schools previously attended and dates:

School	*City*	*Grade Level*	*Dates*

Mother's Name:_____ Mother's Employer:_____
Address:_____ Profession:_____
City:_____ Zip:_____ Social Security #:_____
Home Phone: _____ Work Phone:_____ Cell: _____

Father's Name:_____ Father's Employer:_____
Address:_____ Profession:_____
City:_____ Zip:_____ Social Security::_____
Home Phone:_____ Work Phone:_____ Cell:_____

Stepfather's Name: _____ Stepmother's Name:_____
Step-Siblings' Names and Ages: Step-Sibling's Names and Ages:
_____ _____
_____ _____
_____ _____
_____ _____

Which parent(s) does the child primarily live with?_____

Nearest relative not living with you:_____ Phone:_____

Family Doctor/Pediatrician:_____ Phone:_____

(see other side)

FAMILY MEMBERS

Please list all family members, including parent(s) and siblings.

NAME	BIRTHDATE	AGE	RELATIONSHIP TO CHILD	HIGHEST GRADE COMPLETED	IN/OUT OF HOME

PREVIOUS TESTING

JATP _____ Testing Psychologist_____
Date

Glenz -Blanton_____
Date

Other testing or prep classes_____ Date _____

_____ Date_____

CHILD'S HISTORY

Any complications during pregnancy or delivery?_____ If so, explain:_____

_____

_____

Was your child premature?_____ If so, by how much?_____

Was your child adopted?_____ If so, at what age?_____

How was your child's health during infancy?_____

At what age did your child begin walking?_____ Using words?_____ Short phrases?_____

Describe how much your child talks now:_____

(see other side)

CHILD'S HISTORY (cont'd.)

Any problems with vision?_____ Does your child wear glasses?_____

Any problems with hearing?_____ Chronic ear infections? _____

Has your child ever had ear tubes?_____ Hearing aid?_____

Describe any major illnesses or surgeries your child has had, and at what ages?_____

_____

_____

Is your child currently taking any medications?_____ If so, how much and for what reason?_____

_____

Has there ever been anything about your child's development that has concerned you?_____ If so, describe:_____

_____

_____

Has your child's teacher(s) indicated any concerns regarding your child's:

attention_____, memory _____, language_____, motor skills,_____, other_____

Is English the primary language spoken in your home?_____

Additional languages in which your child is fluent:_____

Please list any major educational problems experienced by immediate family members (parents, siblings), including Attention Deficit Disorder and Learning Disability:_____

_____

_____

Please list the family's greatest sources of stress and concern:_____

_____

(see other side)

Please let us know before the evaluation begins if your child has been sick, irritable, unusually excited or sleep deprived on the day or night before testing. Also, if there is any family, school or peer situation (e.g., a new baby, divorce, financial or marital tension, new or absent teacher), please mention it to me.

RELEASE OF INFORMATION

If my insurance company contacts Spencer H. Gelernter, Ph.D. and Associates:

_____ Do ***NOT*** release any information

_____ Release ***only*** the dates of appointments, clinician's names and diagnostic code

_____ Release ***any*** information requested by my insurance company

Signature_____ **Date**_____

I understand that the results of my child's JATP testing will be sent to each and all of the schools to which we are making application, as indicated on the JATP application form.

Signature_____ **Date**_____

Thank you for completing this questionnaire.