

KATIE LIEBENBERG THERAPY

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CONFIDENTIAL Background Information

Identifying Data

Name of Examinee: _____
Date of Birth: _____
Age: _____
School: _____
Grade: _____

Reason for Referral

Who referred the examinee to testing: _____

What is the purpose of the testing: _____

Please write five words that describe the examinee: _____

Please list the examinee's current problems: _____

Problems eating (if yes, describe): _____

Problems sleeping (if yes, describe): _____

Problems with self-esteem (if yes, describe): _____

Problems with academic self-esteem (if yes, describe): _____

Problems with body image (if yes, describe): _____

Problems with speech/language (if yes, describe): _____

Problems with sensory integration (if yes, describe): _____

Problems with vision (if yes, describe): _____

Problems with auditory processing (if yes, describe): _____

Chronic illnesses (please describe): _____

Rate the examinee's fine motor skills (circle one): Below Average Average Above Average

Rate the examinee's gross motor skills (circle one): Below Average Average Above Average

Has the examinee received OT services (if so, list dates): _____

How is the examinee doing in school: _____

How does the examinee feel about school: _____

Does the examinee have accommodations in school (if so, describe): _____

Rate the examinee's social skills (circle one): Below Average Average Above Average

Please list the examinee's current strengths: _____

What does the examinee do for fun: _____

What does the examinee do for exercise: _____

Developmental and Medical History

Is the examinee adopted (circle one): Yes No

Was conception complicated? If so, how: _____

Was labor complicated? If so, how: _____

Was delivery complicated? If so, how: _____

Length at birth: _____ If unknown, circle one of the following: Normal Abnormal

Weight at birth: _____ If unknown, circle one of the following: Normal Abnormal

Head circumference at birth: _____ If unknown, circle one: Normal Abnormal

At what age did the examinee roll over: _____

At what age did the examinee first sit up: _____

At what age did the examinee crawl: _____

At what age did the examinee walk: _____

At what age did the examinee talk: _____

Who is the examinee's physician: _____ Town: _____

Current height: _____ weight: _____

Please list major or recurrent illnesses (and dates of onset/duration): _____

Does the examinee have allergies (if yes, describe): _____

Has the examinee seen a psychotherapist (if yes, name provider and give dates/duration/frequency of sessions): _____

Has the examinee seen a psychiatrist (if yes, name provider and give dates): _____

Has the examinee seen a neurologist (if yes, name provider and give dates): _____

Please provide medication history (include dates, doses, and prescriber): _____

Please list current medications (include dates, doses, and prescriber): _____

When was the examinee's last physical examination: _____

When was the examinee's last dental examination: _____

Please list any dental problems: _____

When was the examinee's last eye exam: _____

Please list vision problems: _____

Does the examinee wear corrective lenses (circle one): Yes No

When was the examinee's last hearing test: _____

Please list hearing problems: _____

Family and Social History

Where does the examinee live: _____

Who lives with the examinee (include age and sex of siblings): _____

Are the examinee's parents married (if divorced, provide date of separation): _____

Is the family religious (if so, which religion): _____

If religious, does the family attend services (if so, where and how frequently): _____

Has the examinee participated in religious education (if so, any problems?): _____

Does the examinee have close relationships (circle one): Yes No

How many close friends does the examinee have: ____

Does the examinee socialize with peers outside of school (if so, how frequently): _____

Educational History

Please describe the examinee's academic difficulties (if any): _____

Please list all educational institutions attended to date (including preschool): _____

Please list problems and services by grade:

Preschool	
Kindergarten	
1 st grade	
2 nd grade	
3 rd grade	
4 th grade	
5 th grade	
6 th grade	
7 th grade	
8 th grade	
9 th grade	
10 th grade	
11 th grade	
12 th grade	

Please list previous evaluations:

Date	Type	Examiner	Purpose	Findings