

ABCD, INC.
ASSOCIATES IN BEHAVIOR AND CHILD DEVELOPMENT
155 NE 100TH STREET, SUITE 306
SEATTLE, WA 98125
PHONE: 206-361-6884 FAX: 206-361-1598

REGISTRATION FORM FOR PSYCHOEDUCATIONAL EVALUATIONS

Child's Name: _____ Birth date: _____

Child's School: _____ Grade in school: _____

Today's Date: _____ Home Phone: _____

Name of person completing form: _____

Relation to child _____ Does the child live with you? _____

Is this your biological child? _____ Adopted? _____ Your stepchild? _____

Who referred you to ABCD or how did you learn about our services?

Who is your child's physician? _____

Family

Parent #1 name _____ Phone/Cell: _____

Home Address: _____

Parent #2 name _____ Phone/Cell: _____

Address: (if different from Parent #1) _____

Marital Status: Parent #1 _____ Parent#2 _____

Please briefly describe the concerns or problems that led you to seek a psychoeducational evaluation for your child:

Please list any prior testing that has been done by school staff or other specialists (for example, occupational therapy, speech therapy, special education evaluation, etc.)