Swerdlow-Freed
PSYCHOLOGY

TESTING REGISTRATION FORM
CHILD/ADOLESCENT

Name _____ Age _____ Birthdate _____

Parent's Names_____Address _____

City, State & Zip_____

Home phone _____ Work Phone _____

Cell phone _____

List any medications your child is taking _____

Who referred you to our office? _____

May we send a letter thanking them for the referral? Yes___No___Initials_____

Reason for testing:

Note concerns and strengths for your child in the areas below.

Physical development:

Emotional development:

Intellectual abilities:

Interactions with family members:

Social interaction with peers:

Other comments:

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REQUEST FOR EVALUATION

This is to certify that I,_____, grant permission to Swerdlow-Freed Psychology, P.C. to conduct an intellectual assessment of my child, _____. The fee of $400.00 for the assessment will be paid by me in full at the time of the appointment.

_____ _____

Parent Signature Date Witness Date

RELEASE OF INFORMATION

I hereby give permission to Swerdlow-Freed Psychology, P.C. to release the findings of the intellectual evaluation conducted with my child to:

1._____

2._____

3._____

_____ _____

Parent Signature Date Witness Date