LARRY K. GRUBB, MD, PA

CHILD AND FAMILY INTAKE FORM (SHORT-FORM)

Child's Full Name: Date of Birth:
Referred by: Gender: FEMALE / MALE
Primary Care Physician:

Child lives with: MOTHER/ FATHER/ BOTH Other (describe):
Mother's Name: Social Security #:
Father's Name: Social Security #:
Person Responsible for Account:_____

Address: _____
City/State/Zip:

Home Phone #: Work Phone #:
OK to leave message? YES / NO OK to leave message? YES / NO

GOALS FOR THERAPY

What would you like to see happen as a result of your work here? _____

CHILD'S MEDICAL HISTORY

Is your child taking medication? YES / NO If yes, please explain: _____

Has your child ever had any of the following?

Visual Problems	YES / NO	Broken Bones	YES / NO
Hearing problems	YES / NO	Head injury	YES / NO
Allergies	YES / NO	Serious infections	YES / NO
Problems with Coordination	YES / NO	Soiling	YES / NO
Weight loss	YES / NO	Bedwetting	YES / NO
Speech problems	YES / NO	Chronic illness	YES / NO
Seizures	YES / NO	Other:	

List any illness or injuries for which the child required hospitalization or surgical operation:

Illness	Doctor	Date	Hospital

FAMILY SITUATION

CURRENT FAMILY STATUS: single parent involved engaged cohabitating married
separated divorced widowed remarried

MARRIAGES, SIGNIFICANT RELATIONSHIPS, AND CHILDREN:

Partner/Spouse	Beginning Year	Ending Year	Names/ages of children from relationship	Where/with whom do they live?

Mother's: EDUCATION: _____ AGE: _____
EMPLOYER: _____OCCUPATION: _____
Father's: EDUCATION: _____AGE: _____
EMPLOYER: OCCUPATION:

Are any family members experiencing significant medical problems? YES / NO
If yes, please describe: _____

Alcohol/drug/caffeine/tobacco use: Past: _____Present: _____

Have you had previous counseling? YES / NO
If yes, with whom? _____When? _____

May we contact your previous counselor(s)? YES / NO

DEVELOPMENTAL HISTORY

Pregnancy

During the pregnancy, did the mother experience any difficulties (such as German Measles, RH incompatibility, false labor, etc.)? If yes, please explain: _____
_____
Were any drugs (prescribed or non-prescribed), alcohol or tobacco taken during pregnancy?
_____
Were there any problems with other pregnancies (miscarriage, difficult delivery)? Please explain:

Delivery

Duration of pregnancy: _____ Duration of labor: _____Birth weight: _____
Describe any difficulties with the delivery (Caesarian section, breech birth, etc.):
_____
Following birth, did the infant have any difficulties (such as trouble starting to breathe, infections, etc.)?

Development (If you have a baby book…use it)

How old was the child when he/she:
smiled_____ sat without support_____stood_____
walked without support_____used single words (other than mama, dada)_____
combined two words into simple phrases_____spoke in short sentences_____
was bladder trained (day)_____ (night)_____ was bowel trained _____

How would you describe your child's personality
as an infant _____ as a toddler _____

Was the child a cuddly infant or toddler?

PRESCHOOL HISTORY

List any preschool programs you child has attended: _____
_____

List any day care centers your child has attended: _____
_____

Has a private babysitter cared for your child? YES / NO

Has your child's behavior been of any concern at the preschool or day care? YES / NO

If yes, what have the concerns been?

SCHOOL HISTORY

Name of present school: _____

Teacher: _____ Grade Level: _____

Please list other schools attended: _____
_____

Has your child had any difficulties with schoolwork? If yes, please explain: _____
_____

Has your child's behavior been of any concern at school? If yes, please explain: _____
_____

Has your child needed any special help at school? If yes, please explain:

GENERAL INFORMATION

Has your child experienced any serious upset? YES / NO If yes, what kind: _____
_____

Has your child suffered any significant losses? YES / NO If yes, please explain: _____
_____

Is your child clingy? YES / NO Comments? _____

Any problems with eating or appetite? YES / NO Please explain: _____
_____

Does your child have any particular fears? YES / NO Comments? _____
_____

Any problems with sleeping? YES / NO Comments?_____
_____

Any problems with discipline? YES / NO If yes, please describe:_____
_____

How active is your child? _____
_____

Please add any information you feel would be helpful: