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CHILD INTAKE FORM

Any information you provide is confidential and cannot be released without your written consent.

Child's Name: _____Telephone: _____
Address: _____City: _____
State: _____ Zip:_____
Date of Birth:_____

Patient's Employer/School: _____
Telephone:_____
Address: _____ City: _____
State: _____ Zip:_____

Emergency Contact:_____ Relationship_____
Telephone:_____
Cell:_____
Address:_____ City:_____
State:_____ Zip:_____

Person filling out this form: _____

Phone: _____

Who requested that your child be evaluated?
_____

Child's school: _____

Grade: _____

Special placement (if any): _____

Special Ed: _ Yes _ No

Briefly state the reason for this
visit:_____
_____
_____
_____
_____

Current Living Situation

Child is presently living with:
Biological Mother _ Stepmother _ Adoptive Mother _ Foster Mother _ Other _____ _
Natural Father _ Stepfather _ Adoptive Father _ Foster Father
How many people currently live in the household? _____

Family History:

Adoption

Is this child adopted ? _ Yes _ No If so, please briefly describe the age of the child when adopted and the circumstances of the adoption:

_____
_____

Biologic Mother

Name: _____ Age: _____
Highest grade completed:_____
Occupation:_____

Has the biologic mother or any of her relatives experienced any of the following psychological or emotional difficulties? _____
Do any medical illnesses run in the biologic mother's family (i.e., thyroid, diabetes, seizures, movement problems such as tics or other neurological problems, allergies, etc.)?

_____

Biologic Father

Name: _____ Age: _____
Highest Grade Completed: _____ Occupation:
_____
Has the biologic father or any of his relatives experienced any of the following psychological or emotional difficulties
_____

Parents

How long have the child's parents been: Married:_____ Separated:_____ Divorced:_____ Living together:_____
If the parents are separated or divorced, please describe custody (physical and legal) and visitation rights.

_____
_____
If married, describe current relationship (i.e., supportive, conflictual, etc.):

_____
_____
Please list any previous marriages:

_____
Are there currently any significant marital stressors? _ Yes _ No *If so, please briefly explain*: _____

_____
_____

Siblings (Brothers, Sisters, Cousins)

Sibling In Home?
_____ _____ _____

Have any of the siblings experienced psychological or emotional problems (suicide or suicide attempts, attention or learning difficulties, legal problems, alcohol or substance abuse, social difficulties, or medical problems)? If so, please state who and the nature of the problem.

_____
_____
_____
Are there any other relatives or persons living in the home?

_____
_____
Please list *(current or past)* significant areas of conflict in the home between this child and others.

_____
_____

Birth History

Mother's age at time of birth: _____ Years Father's age at time of birth: _____Years

Did the mother smoke during the pregnancy? _ Yes _ No *If so, how many cigarettes per day*: _____
Was alcohol consumed during pregnancy? _ Yes _ No *If so, what was the amount per day?* _____
Were any drugs used during the pregnancy? _ Yes _ No
If so, list the name of the drug and amount:_____

Was the child premature? _ Yes _ No Number of weeks late: _____ Number of weeks early:_____

Were you under anesthesia during childbirth: _ Yes _ No *If yes*, _ Local _ Spinal _ General

Was the delivery unusual in any way? _ Yes _ No *If yes, please explain*: _____
_____
Did you have a cesarean? _ Yes _ No *If yes, please describe complications:* _____

Was this baby normally active? _ Yes _ No Baby's birth weight: _____ Apgar Scores (if known) _____
Were any birth defects evident? _ Yes _ No *If yes, please describe:*
_____
What was the number of days the infant was in the hospital after delivery?
_____
Please add any comments regarding your pregnancy or delivery:
_____

Infancy Period

Did the mother have problems with depression after the birth? _ Yes _ No
If yes, please briefly describe:
_____
_____
Did either parent have significant problems adjusting after the birth? _ Yes _ No
If yes, please briefly describe:
_____
_____
_____
Describe any physical or emotional separations from the caregivers in the first few years of life:
_____
_____

Was this child: _ Breast fed _ Bottle fed

Developmental History

Motor development (sitting, crawling, walking): _ Average _ Early _ Late
Speech and language: _ Average _ Early _ Late
Self-help skills (dressing, brushing, hygiene, etc.): _ Average _ Early _ Late
Bowel trained: _ Average _ Early _ Late Age _____
Bladder trained: _ Average _ Early _ Late Age _____
Started to read: _ Average _ Early _ Late Age _____

Coordination

Handedness: _ Left _ Right _ Both
Rate this child on the following skills:
Good Average Poor
Writing: _____ _____ _____
Athletic abilities: _____ _____ _____
Does this child have an excessive number of accidents compared to other children? _ Yes _ No
If yes, please describe: _____

Behaviors, Moods, and Attitudes

(Infancy, Toddler, Preschool)

Check all that apply:

_ adaptable _ rocking _ able to play alone _ difficulty with attention

_ impulsive _ easy to manage _ underactive/passive _ deals well with frustration
_ stubborn _ dare-devil _ eating difficulties _ difficulty with changes
_ cautious _ shy or timid _ sleeping difficulties _ responds well to challenges
_ moody _ easily frustrated _ aggressive/violent _ obsessive or compulsive
_ sensitive _ empathic _ wants to be left alone _ more interested in things than people
_ playful _ severe tantrums _ slow to warm up _ overwhelmed by challenges
_ fearful _ curious _ temper outbursts _ overactive/into everything
_ angry _ staring spells _ breath holding spells _ difficulties in interactions with others
_ happy _ affectionate _ head banging _ stuttering/speech problems
_ sad _ irritable

Were any of the following present, to a significant degree, during the first year of life? *If so, please describe:*

_ Did not enjoy cuddling:
_____

_ Was not calmed by being held:
_____

_ Was difficult to comfort:
_____

_ Was colicky:
_____

_ Was excessively restless:
_____

_ Was excessively irritable:
_____

_ Experienced sleep difficulties:
_____

_ Experienced difficulty with nursing or food:
_____

Current Behaviors, Moods, Attitudes:

How would you describe this child's conscience? _ Normal _ Lax _ Harsh _ Preoccupied with certain issues
Do you have any concerns about this child's self esteem? _ Yes _ No *If yes, please describe:* _____
_____

Do you have any concerns with regard to this child's sexual knowledge or awareness? _ Yes _ No
Gender identity? _ Yes _ No Sexual orientation? _ Yes _ No *If yes, please describe:* _____
_____
_____

Please check any of the following that this child has problems with (currently or in the past):
_ bed wetting _ involuntary vocalizations _ obsessive-compulsive behaviors _ depression
_ soiling _ significant weight change _ self-conscious, embarrassed _ shy, withdrawn
_ sleep problems _ oppositional, defiant _ frequent arguing _ fearful
_ eating problems _ immaturity _ secretive _ crying episodes
_ sexual problems _ anxiety, panic _ extreme moodiness _ irritability, anger
_ lying _ stealing _ cruelty to animals _ setting fires
_ poor motivation _ change in personality _ suspicious, distrustful _ hallucinations
_ alcohol abuse _ other substance abuse _ strange ideas or behaviors _ impulsiveness
_ explosive episodes _ property destruction _ self-destructive behaviors _ running away
_ aggression, violence _ frequent accidents _ suicidal talk or behaviors _ guilt
_ hopelessness _ Other
_____

Please list the types of discipline you have tried with this child and its effectiveness:
_____
_____
_____

Please check any of the following significant events that have occurred within your family and briefly describe:

_ death of a family member or significant person: ____

_significantmoves:____

_trauma:_____

_ divorce/separations:
_____
_ serious illness of a family
member:_____
_ parental unemployment:
_____
_ financial stress:
_____
_ trouble with the law:
_____
_ other:
_____

Please express any additional concerns regarding this child:
_____
_____
_____

Please list this child's strengths (i.e., academic, athletic, personality, creativity, funny, etc.):
_____
_____
_____

Comprehension and Understanding

Do you consider this child to understand directions and situations as well as other children his/her age?
_ Yes _ No
If not, please explain:
_____
_____
If this child tells a story about a show, event, etc., do you or others have difficulty understanding him/her?
_ Yes _ No
If yes, is it because he/she (check all that apply):
_ appears confused _ is disorganized _ leaves out important information
_ loses train of thought _ has trouble finding the right words
Does this child have trouble remembering things that he/she really cares about? _ Yes _ No
Please describe:
_____
_____

Does this child have difficulty following routines (bedtime, dressing, etc.)? _ Yes _ No
Please describe:
_____
_____

Does this child frequently lose things or have trouble being organized? _ Yes _ No
Please describe:
_____
_____

How would you rate this child's overall level of intelligence compared to other children?
_ Above Average _ Average _ Below average

Free Time

Please describe how this child generally spends her/his free time (i.e., plays alone, plays with friends, plays sports, watches TV, plays video games, etc.):
_____
_____

Please list the approximate number of hours per day that this child watches TV and list the type(s) of shows watched:

_____

_____

Please list the approximate number of hours per day that this child plays video games and list the type(s) of games played:

_____

_____

Independent Activities Please describe this child's ability to function in an independent manner:

_____

_____

_____

School History

Did this child attend daycare or preschool? _ Yes _ No
If yes, please estimate approximately how many hours per week:
_____
What are your current care arrangements for this child before and after school?
_____
_____

Beginning with kindergarten, list school and indicate performance:
Academic Performance- Behavioral -Performance
Grade School
KG
_____
1st
_____
2nd
_____
3rd
_____
4th
_____
5th
_____
6th
_____
7th
_____
8th
_____
9th
_____
10th
_____
11th
_____
12th
_____

Are there any known learning disabilities? _ Yes _ No

If yes, please list:
_____
_____

Has this child been in any special programs (speech, reading, occupational therapy, etc.)? _ Yes _ No
If yes, please explain and list grades:
_____
_____

Has this child ever had to repeat a grade? _ Yes _ No
If yes, please explain:
_____
_____

Current Academic Performance

_ Excellent _ Good _ Satisfactory _ Unsatisfactory _ Failing
Does this child enjoy school? _ Yes _ No
School subject strengths:

_____

School subject weaknesses:

_____

Check any of the following problems this child has with school:
_ problems with written language _ poor handwriting _ poor at spelling _poor reader
_ does not remain seated _ frequently sent out of class _ too withdrawn or passive _impulsive
_ forgets instructions _ difficulty being _quiet _ interferes with other's tasks _poor at math
_ requires additional supervision _ talks inappropriately _ makes careless mistakes _daydreams
_ messy and disorganized _ non-compliant in class _ oppositional with teachers _skips school
_ does not complete classroom work _ fails to check homework _ difficulties in groups _test anxiety
_ does not do homework _ difficulties with peers _ poor attention
_ excessive time to complete assignments

Is this child involved in extracurricular activities? _ Yes _ No

If yes, please describe:

_____
_____
_____

Any additional comments regarding school functions?

_____
_____
_____
_____
_____

Peer Relationships

Does this child seek friendships with peers? _ Yes _ No Is this child sought by peers for friendship? _ Yes _ No
Check any of the following which describes this child's interactions with peers?
_ plays well in groups _ plays well in groups _ plays well in groups _ teased by other kids
_ no problems _ cooperative _ supportive _ shares well
_ plays primarily with younger _ plays primarily with older _ afraid other kids do not _ trouble making friends
_ loses friends _ no friends _ few friends _ rejected by other kids
_ easily led by others _ aggressive or mean _ frequent arguments _ frequent fights
_ bossy and controlling _ teasing _ jealous _ bragging/boastful
_ uncooperative _ feelings get hurt easily _ involved in risky or dangerous behavior
_ involved in alcohol or substance abuse _ involved in delinquent behavior

Child's Medical History

If this child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.
_ hospitalizations _____ _ operations _____
_ handicaps or deformities _____ _ failure to grow _____
_ pneumonia _____ _ asthma _____
_ allergies _____ _ diabetes _____
_ skin problems _____ _ multiple ear infections _____
_ tubes placed _____ _ seizures _____
_ persistent high fevers _____ _ obesity _____
_ movement problems (tics, repetitive movements) _____
_ head injury (with loss of consciousness)
_____
_ other physical trauma _____ _ coma _____
_ encephalitis _____ _ eye problems _____
_ hearing problems _____ _ anemia _____
_ stomach problems _____ _ constipation _____
_ poisoning _____ _ other _____

Has this child ever had a neurologic evaluation (exam, MRI, CAT Scan, EEG, etc.)? _ Yes _ No
If so, please describe:

_____
_____
_____

Has this child's vision been tested? _ Normal Date: _____
His this child's hearing been tested? _ Normal Date: _____

List medications that have been used for over one month's duration. (If additional space is needed, please continue on reverse side.)
Problem-Medication-Dos- Started-Stopped-Side Effects-Response
_____
_____ _____
_____

Child's Present Medical Status

Height: _____ Weight: _____
Medical Doctor: _____
List any present illness(es) for which this child is being treated:
_____
_____
What was the date of this child's last physical exam? _____
Was blood work done? _____
Describe this child's appetite and diet:
_____
_____
List all medications this child is currently taking for medical problems:
Date Date Side
Problem Medication Dose Started Stopped Effects Response
_____
_____
_____ _____
Have there been any allergic reactions to medications? _ Yes _ No *If so, please describe:*
_____
_____
Does this child frequently complain of: *(Please check all that apply.)*
_ headaches _ dizziness _ sleep problems _ nightmares _stomachaches
_ staring into space _ tiredness _ difficulty breathing _ painful urination _chest pain
_ trouble with vision _ trouble hearing _ menstrual problems _ skin problems _palpitations
Who is this child's current medical doctor?
_____
May we contact him/her if needed? _ Yes _ No

How does this child sleep at night?
_____
_____

Previous Treatments

Has your child ever received any type of psychiatric, psychological, or academic evaluation or treatment?
_ Yes _ No

If so, please fill in the following:

Person or Institution Dates Address Telephone
_____
_____
_____

Has this child ever taken psychiatric medications? _ Yes _ No

If yes, please list:

Date Side
Problem Medication Dose Started Stopped Effects Response

Have you been satisfied with previous mental health care (if applicable)?

Current/Previous Natural Treatments

Please list any vitamins, remedies, or holistic treatments you use with this child.

Spiritual Orientation

Please list your family's spiritual orientation or religion:

How active are these beliefs in your life? _ Very active _ Somewhat active _ Not very active
If you like, share some of your thoughts on your spiritual practice/religion:

In Conclusion

Please make any additional comments you wish with regard to this child:

Thank you for your patience and hard work in completing this form.
It will help me enormously in my work with you.