Client Intake Form

Patient/Child's Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

School: _____ Grade: _____

Home Address: _____ City_____ ST ____Zip_____

Home Phone: _____ Name of person filling out this questionnaire: _____

Person who referred you: _____ May we thank this person? Y N

Parent Information

Father: _____ Age:_____

Address (if different):_____

Daytime Phone: _____ Cell Phone:_____

Education: _____Occupation: _____

E-Mail _____

Mother: _____ Age:_____

Address (if different):_____

Daytime Phone: _____Cell Phone: _____

Education: _____ Occupation: _____

E-mail_____

Parents are: married separated divorced re-married deceased

Who has custody? _____

Sole Custody? Y N if yes, you must have legal documentation with you when you come.

Joint Custody? Y N We will need both parents' signatures before testing.

Referral Information

Problem Statement:_____
_____

Describe your child's strengths: _____
_____
_ _____

Describe some of your child's weaknesses: _____
_____
_____

Do both parents agree about the nature and causes of the problem? _____

If not, please explain: _____
_____
_____

How do you discipline your child? _____

What is the result? _____
_____
_ _____

What do you hope to learn as a result of the evaluation? _____
_____
_ _____

Child is: biological adopted (at what age); foster (how long?)

Does the child prefer one parent over the other? Y N Which one? _____

Why? _____
_____

List Siblings and their ages: _____
_____
_____

Others living in home:_____

Is child in day care? Y N If so, how many hours/day? _____

Pregnancy and Birth History

Age of mother at delivery: _____ Age of father at delivery: _____

Number of prior pregnancies: _____

Number of prior miscarriages: _____Was a fertility specialist consulted? _____

Living circumstances during pregnancy: _____
_____

Known health problems of mother during pregnancy (circle all that apply)

Toxemia	Hypertension	Gestational Diabetes	Trauma
Fever	Allergies	Smoking	Alcohol Use
Drug Use	Antibiotics	Depression	Anxiety
Blood Incompatibility	Injury	Accidents	Emotional Abuse
Physical Abuse	Sexual Abuse	Spouses abuse:	Other:
Mental Illness	Sexually Trans. Disease	Other:	Other:

Please explain: _____
_____

List any medications, tobacco use, alcohol use, or drugs taken by mother during pregnancy: _____
_____

Delivery: Vaginal Cesarean If Cesarean, reason? _____

Full Term Premature

Weeks Gestation_____ Time spent in labor _____hours Birth Weight____ lbs. ____oz

Circle any birth complications that apply:

Feet first	Cord around next	Meconium staining	Lacking oxygen
Jaundice	Not breathing	Other:	Other:

Explain: _____

Apgar scores: _____ How old was baby at discharge from the hospital after birth? _____

Please explain any medical problems after discharge and interventions: _____
_____

Any problem in first few months? _____

Did you experience postpartum (after birth) depression? _____

Developmental History

Speech/Language:

Child's first language _____ Language spoken in the home _____

Age spoke first word_____ Age put 2-3 words together (short sentences)_____

Circle all that apply:

Speech delays	Stuttering	Hard to Understand	Late Drooling
Poor Sucking	Poor Chewing	Articulation Problems	Slow to learn alphabet
Slow to learn colors	Slow to learn counting	Other: _____	Other: _____

Please list any speech therapy services your child has received _____
_____
_____

Motor:

Age sat alone: _____ crawled: _____stood alone:_____ walked alone:_____

Was your child slow to develop motor skills or awkward compared to siblings/friends (e.g., running, skipping, climbing, biking, playing ball?) Y or N Explain:_____

Handedness: Right Left Ambidextrous (both)

Family history of left-handedness (list relatives)? _____

Please list any physical or occupational therapy services your child has received _____
_____

Toileting:

Age when toilet trained_____

Problems with: Bedwetting Urinating Soiling Explain: _____
_____

Any current problems? _____
_____

Medical History

Has vision been checked? Y or N Any problems: _____

Has hearing been checked? Y or N Any problems: _____

CT or MRI Date obtained? _____ Results: _____

EEG Date obtained? _____ Results:_____

Other tests and results:_____

List serious illnesses/injuries/hospitalizations/surgeries

Date	Incident (explain)
_____	_____
_____	_____
_____	_____

Circle all that apply:

Failure-to-thrive	Febrile seizures	Epilepsy	Staring spells
Head injuries	Meningitis	Encephalitis	Asthma
Allergies	Diabetes	Loss of Consciousness	Abdominal pains
Vomiting	Headaches	Ear infections	Sleep difficulties
Sleep walking or talking	Eating difficulties	Eating disorder	Facial or other Tics
Repetitive movements	Impulsivity	Temper tantrums	Nail biting
Clumsiness	Head banging	Self-injurious behavior	
Physical injuries	Lead poisoning/toxic ingestion		
Other: _____	Other: _____	Other: _____	Other: _____

Please explain the age of occurrence, relevant information, and interventions of any conditions circled above:

_____

_____

_____

Current medications and reasons: _____

Child's Pediatrician and address: _____

Psychological and Treatment History

Family History (circle all that are present; include parents, siblings, aunts, uncles, maternal and paternal grandparents):

Learning Difficulties	Mental Illness	Neurological Illness	Seizures
Psychiatric Disorder	Schizophrenia	Depression	Bipolar Disorder
Anxiety	Suicide	Alcoholism	Drug Abuse
Legal Problems	Arrests	Obsessive-Compulsive Disorder	Personality Disorder
Other: _____	Other: _____	Other: _____	Other: _____

Please explain:

_____

_____

_____

Does anyone else in the family have a problem similar to your child's reason for referral?_____

_____

Child history

Has your child experienced (circle all that apply):

death of a loved one	separation from a loved one	emotional trauma	sexual abuse
family conflict	marital conflict	physical abuse	emotional abuse

Please explain_____

_____

_____

_____

Please list current and past psychologists, social workers, psychiatrists, counselors, outpatient and inpatient treatment, cognitive evaluations, neuropsychological evaluations, psychological testing, etc.

Name/ Occupation	Dates Seen	For What?	Describe Progress

Please add any additional information you would like us to know: _____

Social Behavior

My child (circle all that apply)

Gets along with peers	Gets along with older children	Has a sense of humor	Gets along with adults
Keeps friends	Understands others' feelings	Understands social cues	Bullies others
Initiates play	Has problems with peer pressure	Is "bossy"	Is bullied by others
Is teased at school	Gets along with siblings	Initiates bad behavior	Has empathy for others

Please explain any pertinent issues regarding your child's social behavior: _____
_____
_____
_____

Does your child make and maintain friendships? Y N Does your child have any close friendships? Y N Please explain:
_____
_____
_____
_____
_____
_____

Does your child have particular sensitivities (i.e., food, tags on clothing, etc.)? _____
_____
_____
_____
_____

Educational History

Current school and address: _____

Grade: _____ Placement: Gifted Regular Special Education (IEP)
Other_____

Any grades that were skipped? _____ repeated? _____

Teachers report problems in: _____
_____

Reading Spelling Arithmetic Writing

Attention Behavior Social Adjustment Hyperactivity

Impulsivity Easily Distracted Other: _____ Other: _____

Please describe the above noted problem(s) _____
_____
_____

Grade:	Academic problems? (Please describe)
_____	_____
_____	_____
_____	_____
_____	_____

Has your child been evaluated for special education? Y or N (If yes please provide a copy of the evaluation_____

_____

Do teachers report problems that you do not notice? Y or N
_____
_____
_____
_____

Do you see problems that teachers don't notice? Y or N _____
_____
_____