



## 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
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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 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_