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Intake Form - Parents

Date: _____

Legal Name: _____ Gender: _____

Date of Birth: _____ Current Age: _____ Preferred pronouns: _____

Current Grade: _____ School Name: _____

Home Address: _____

Home Phone: _____

Parent name: _____ phone: _____ DOB_____

Email Address: _____

Can this person pick your child up in the event of an emergency? Y/N

If not, who can?_____

Parent name: _____ phone: _____ DOB_____

Email Address: _____

Can this person pick your child up in the event of an emergency? Y/N

If not, who can?_____

Insurance:

Company_____ Policy Number: _____

Card holder name: _____ Card holder DOB: _____

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Family information:

Mother Age: _____ Education: _____ Occupation: _____

Father Age: _____ Education: _____ Occupation: _____

Child lives with: □ Both Parents □ Mother □ Father

□ Father and Stepmother □ Mother and Stepfather □ Legal Guardian

□ Other:_____

Parents' relationship: □ Single □ Married □ Separated □ Divorced □ Widowed

How long married?: _____ How long divorced?: _____ Child's age at divorce _____

Are you involved in or planning to pursue litigation regarding child custody? □ Yes □ No

If yes, please explain: _____

Was the divorce amicable? _____

Is the child adopted? □ Yes □ No Child's age at adoption _____

Where was the child adopted from?_____

Early developmental concerns you are aware off? _____

_____

Are there other children in the family?

Name	Age	Gender	Relationship	Behavior concerns	Diagnosis
_____				□ Yes □ No	_____
_____				□ Yes □ No	_____
_____				□ Yes □ No	_____

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Referral Information/Chief Complaint

Have your child been diagnosed in the past? Yes ☐ No ☐

Who diagnosed? Age at diagnosis Diagnosis:

Person who referred you: _____

What are the problems that caused you to seek an evaluation for your child?

1._____

_____

2. _____

_____

3. _____

_____

When did you notice your child's behavior becoming problematic? _____

_____

Was the change gradual or sudden? _____

_____

Was there an event that coincided with the change (e.g., friend moved away, new school) ?

_____

Do both parents agree about the nature of the problem? □ Yes □ No

_____

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What specific goals do you hope to accomplish through this program?

1. _____

2. _____

3. _____

Describe some of your child's strengths: _____

_____

_____

Describe some of your child's weaknesses: _____

_____

Emotional Development:

Please describe your child's personality: _____

_____

Please describe your child's typical mood: _____

_____

Please check each of the following symptoms that you have observed in your child.

□ Headaches	□ Dizziness
□ Coordination problems	□ Balance problems
□ Tremors or shakiness	□ Concentration problems
□ Loss of feeling, tingling, or numbness	□ Easily Fatigued
□ Difficulty producing words clearly	□ Pain
□ Sensitivity to light or noise	□ Easily distractible
□ Difficulty remembering the right word	□ Difficulty planning or organizing
□ Difficulty reading or writing	□ Personality changes

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□ Difficulty finishing tasks
□ Trouble getting started on tasks
□ Apathy, lack of interest in things
□ Irritability
□ Black-out spells
□ Temper outbursts
□ Restlessness
□ Gets bored quickly
□ Mood swings
□ Anxiety/tension
□ Depression
□ Troubling thoughts (e.g. worries, fears)
□ Loss of confidence
□ Loneliness
□ Changes in appetite
□ Feelings of guilt
□ Increased suspiciousness

Pregnancy and Birth History

Age of mother ___ and father ___ at delivery? Any known health problems while pregnant?
□ vaginal bleeding □ toxemia □ hypertension □ gestational diabetes

□ trauma □ fever/rash (e.g., flu, measles?) □ depression/emotional problems

□ blood incompatibility □ injury □ other: _____

Medications taken during pregnancy:_____

_____

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

Type Frequency of use Month during pregnancy stopped (if applicable)

_____

_____

Delivery was: □ vaginal □ cesarean, reason _____

Baby was: □ full term □ premature, by ___ days/months

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Birth complications? □ feet first □ cord around neck □ meconium staining □ lacking oxygen-blue □ jaundiced-yellow, other:_____

Birth Weight: _____ Length: _____ APGAR scores: _____

Please list any problems and birth defects: _____

_____

Did you experience postpartum (after birth) depression? □ Yes □ No

If yes, was it treated and how: _____

Please describe any other health problems, problems in the family, problems with infant/mother bonding during infancy or early development:_____

_____

Developmental History

Infant and Toddler Behavior

Circle any of the following that were problematic for your child as an infant or toddler:

colicky	irritable	feeding problems	sleeping problems
restlessness	overactive	did not enjoy cuddling	tantrums
cautious/careful	accident prone	uncoordinated	avoided eye contact

disliked contact with people

Please elaborate: _____

_____

Motor

(Gross) Age sat _____ crawled _____ walked alone _____ ran well _____

(Fine) Age fed self with spoon _____ scribbled _____ tied shoes _____

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

Was physical or occupational therapy ever necessary?_____

_____

Language

Age said first word _____ repeated phrases _____ used sentences (2+ words) _____

Oral motor problems (e.g., drooling, poor sucking, poor chewing)? Describe: _____

_____

Was speech/language therapy ever necessary?_____

Was your child slow to learn: the alphabet? □ Yes □ No name colors? □ Yes □ No

count? □ Yes □ No body parts? □ Yes □ No basic commands? □ Yes □ No

Primary language spoken at home: _____ Other languages spoken: _____

Toileting

Age toilet trained for bladder control _____ Age toilet trained for bowel control_____

Problems with bedwetting, urine accidents, soiling? □ Yes □ No Until what age? ____

Specify_____

Any current problems? _____

Social

Does your child have difficulty with any of the following:

Getting along with children?	□ Yes □ No	Getting along with adults?	□ Yes □ No
Making friends?	□ Yes □ No	Keeping friends?	□ Yes □ No
Understanding gestures?	□ Yes □ No	Sense of humor?	□ Yes □ No

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Understanding social cues (e.g., recognizing when someone is not interested)? □ Yes □ No

Peer pressure (i.e., will follow his friends without proper judgment)? □ Yes □ No

Explain:_____

_____

Nutrition & Sleep Hygiene

How many hours per day does your child sleep? _____ When do they go to bed? _____

When do they wake up in the morning? _____ Do they take naps? □ Yes □ No

If yes, how often _____ (per day) and how long _____ (minutes/hours) are their naps?

Have you noticed that your child:

□ snores loudly
□ seems to have restless sleep

□ stops breathing briefly while asleep
□ is excessively sleepy during the day

□ breathes through their mouth
□ often has morning headaches

□ has night terrors and/or nightmares
□ is afraid of the dark

How would you describe your child's eating habits: □ average/good

□ overeater □ undereater □ eats balanced diet □ eats too much junk food

□ goes for long stretches of the day without eating/erratic eating schedule

□ eats a very limited diet, explain:_____

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Attention and Concentration

Do you experience your child as being hyperactive? □ Yes □ No

Do you experience your child as being inattentive? □ Yes □ No

Do you think your child has a behavior problem? □ Yes □ No

Has your child ever been diagnosed by a psychologist, physician, or other professional as having attention deficit hyperactivity disorder (ADD/ADHD): □ Yes □ No

If yes, when? _____

Excluding medication, what treatment has the child had for ADHD? _____

_____

What medication (including dosage and time) has your child received for ADHD?_____

_____

Life Stressors

Has your child ever been physically, emotionally, or sexually abused? □ Yes □ No

_____

_____

Do you think your child may be the victim of bullying? □ Yes □ No

Please describe observations: _____

_____

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Has your child been exposed to:	Y	N	Please explain
Death of close or significant person?			
Illness of himself or another significant person?			
Hospitalization of the child, parent or sibling?			
Accident that the child was involved in or witnessed?			
Long separations?			
Divorce?			
Sexual hurt?			
Witnessing fight or violence in the family? (Outburst, cursing, hitting)			
Threats for leaving or hurting?			
Other events that might influence your child?			

Educational History

For each of the following grades please note academic or behavior problems:

Nursery school _____

Kindergarten _____

1st grade _____

2nd grade _____

3rd grade _____

4th grade _____

5th grade_____

6th grade _____

7th grade _____

8th grade _____

9th grade _____

10th grade _____

11th grade _____

12th Grade _____

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Teachers currently report problems with:

Reading _____ Writing _____ Attention/Concentration _____

Spelling _____ Behavior _____

Arithmetic _____ Social Adjustment/Peer Relations _____

Do teachers notice problems that you do not notice? _____

_____

Does your child have an IEP or 504 plan (please bring a copy)? _____

Do you feel your child is getting adequate services at school? _____

_____

Are you in the process of or considering litigation regarding your school districts servicing of your child's needs? _____

Family Education History

Has anyone in your family (e.g. parents, siblings, cousins) had any of the following?

□ Special education? Explain: _____

□ Any grades repeated? Explain: _____

□ Learning difficulties? Explain: _____

□ Behavior problems and treatments received? _____

_____

□ Attention Deficit Disorder or Hyperactivity, and treatments received? _____

_____

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Medical History

How would you rate your child's current health: □ Poor □ Fair □ Good □ Excellent

Date of last physical checkup: _____

Did the pediatrician express any concerns? _____

Date of last hearing test: _____ Were the results normal? □ Yes □ No

If no, please explain: _____

Date of last vision test: _____ Were the results normal? □ Yes □ No

If no, please explain:_____

Has your child ever had a: CT scan? □ Yes □ No

MRI? □ Yes □ No

EEG? □ Yes □ No

Date of test and results: _____

_____

Please list any medication being taken by your child (with dosages and time) including nonprescription medications:_____

_____

List serious illnesses/ injuries/ hospitalizations/surgeries:

Date Incident (explain)

_____ _____

_____ _____

_____ _____

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Does your child have a history of:

□ Failure to thrive
□ Epilepsy
□ Lead poisoning/toxic ingestion
□ Asthma
□ Loss of Consciousness
□ Headaches
□ Sleep difficulties
□ Tics/twitching
□ Impulsivity
□ Nail biting
□ Head banging
□ Allergies
□ Febrile seizures (fever associated)
□ Staring spells
□ Meningitis or encephalitis
□ Diabetes
□ Abdominal pains/vomiting
□ Frequent ear infections
□ Eating difficulties/disorder
□ Repetitive stereotypic movements
□ Temper tantrums
□ Clumsiness
□ Self-injurious behavior

If yes, what are they allergic to?: _____

_____

□ Head Injury (blackouts, dizziness)

□ If your child had a head injury, did they lose consciousness? □ Yes □ No

If yes, for how long? _____

Were there any changes in behavior after? _____

Was your child comatose? □ Yes □ No If yes, for how long? _____

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Family Medical History

Do you (the parents) or any extended family (maternal and paternal grandparents, aunts, uncles, cousins) have problems with any of the following?

□ Learning disability	□ Neurological illness	□ Seizures
□ Epilepsy	□ Migraines	□ Heart Disease
□ Stroke	□ Dementia (e.g. Alzheimer's)	□ Parkinson's Disease
□ Multiple Sclerosis	□ Cancer	□ Depression
□ Alcoholism	□ Drug Abuse	□ Schizophrenia
□ Anxiety	□ Attention Deficit Disorder	□ Bipolar (Manic-Depression)

Other psychiatric disorder □ Yes □ No Explain: _____

Any other relevant family medical history?: _____

Any other comments you would like to make:

_____

_____

_____

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Current provider's information:

Pediatrician: _____ phone: _____

Email Address: _____

Psychiatrist / NP: _____ phone: _____

Email Address: _____

Speech: _____ phone: _____

Email Address: _____

OT: _____ phone: _____

Email Address: _____

Other: _____ specify: _____ phone: _____

Email Address: _____

Please list previous therapeutic services that you as a family, or your child have received

Name of profession	Dates	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

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