Dear Parent/Guardian,

Please fill out this form in as much detail as possible. We appreciate your taking time to provide us with this information which will help us understand your concerns and make an accurate diagnosis.

CHILD INTAKE/HISTORY

Name of person completing the form

Last First

Relationship to the Child

Child's Name

Last First Middle Initial

Age Date of Birth / / Place of Birth

(mm/dd/yyyy) City/US State/Country

Grade School

Home Street Address

City State Zip

Home Phone Number Alternate Phone Number

Emergency Contact Person's Name Phone FAMILY INFORMATION

Mother's Name

Age Date of Birth / / Occupation: Education

Phone (Home) (Work) (Cell)

Email Address

Age at time of Marriage Age at time of Birth of Child

Father's Name

Age Date of Birth / / Occupation: Education

Phone (Home) (Work) (Cell)

Email Address

Age at time of Marriage Age at time of Birth of Child

*If parents living apart, other parent's: Home Phone Number

Street Address

City State Zip

Household Composition

Name

(Last, First)

Age

Relationship

Education

Occupation

Family Members/Significant Others not in household

Name

(Last, First)

Age

Relationship

Phone#

Occupation

How does your child get along with:

Mother? Father? _____ Sister(s)? _____ Brother(s)?_____ Other family members? _____

Is child living with both biological parents? Yes No

If not, please explain_____

_____ MEDICAL AND HEALTH INFORMATION

Current Height_____ Current Weight

Has your child had any surgery, serious illnesses or accidents? Yes No

Does your child have allergies? (Environmental or food allergies) Yes No

Does your child have asthma or any other respiratory problems? Yes No

Does your child have any medical conditions? Yes No

If you answered yes to any of the above questions, please explain: _____

_____

_____

Does your child take any medications regularly? Yes No

If yes, please list Name, dose, frequency):

_____

_____Has your child ever been examined by:

Ear, Nose, and Throat Doctor? Yes No

Neurologist? Yes No

Psychologist? Yes No

Other Medical Specialist Yes No

If yes, please explain reason for visit and outcome: _____

_____

Please give place and dates of any previous evaluations or therapy:

Hearing: _____ _____

Vision: _____

Physical Therapy: _____ Occupational Therapy: _____

Speech/Language Therapy: _____

Psychotherapy: _____

Other: _____

Has your child's hearing ever been tested? Yes No

Results: Normal Hearing Impairment (please explain) _____ Does your child have a history of ear infections?

None Rarely 1-2 times /year 3-4 times /year 5 or more times/year

What treatment was provided for your child's ear infections? _____

Has your child ever had tubes in his or her ears or other ear surgery? Yes No

If yes, please explain_____

Does your child have any vision problems? Yes No

If yes, please explain_____

How would you describe your child's overall health? Good Poor

Pediatrician's name

Practice

Phone number: PRENATAL HISTORY

While pregnant, did mother have:

a. High blood pressure Yes No

b. Excessive Vomiting Yes No

c. Bleeding or spotting Yes No

d. Kidney Disease Yes No

e. Toxemia Yes No

f. Gestational diabetes Yes No

Threatened Miscarriage Yes No

g. German Measles (Rubella) Yes No

h. Illness other than cold or flu Yes No

i. Hospitalization Required Yes No

j. Premature labor Yes No

Was there any substance/alcohol abuse? Yes No

If yes, please explain_____

_____

Did mother take any medications during pregnancy Yes No

If yes, please explain_____

_____ BIRTH HISTORY

Where was baby born: _____

Was labor induced: Yes No

Was labor helped by medication: Yes No

Duration of labor: _____

Was baby born early: (less than 38 weeks) Yes No

Was baby born late (after 42 weeks) Yes No

What was the method of delivery?

Spontaneous vaginal Forceps

Breech Caesarean

Reason_____ Birth weight of baby:_____ During hospital stay, did baby have any of the following:

a. Jaundice

b. Antibiotic treatment

c. Rash

d. Blue spells

e. Convulsions Yes No

f. Remain in hospital longer than mother Yes No

g. Incubator Care Yes No

h. Infection Yes No DEVELOPMENTAL HISTORY

Approximate age at which your child reached these developmental milestones:

Age

If exact age not known; it occurred

Early

Late

Normal

Hold up head

Roll over

Sit unsupported

Respond to Own Name

Crawled

Stand alone

Walk

Talk

Toilet train

Feed her/himself

Dress her/himself

Jump

Yes

Ride a Tricycle

Read

Throw & Catch a Ball

Name Colors

Please mark any areas which constitute a problem for your child:

a. Eating Yes No

b. Sleeping Yes No

c. Nightmares Yes No

d. Thumb sucking Yes No

e. Nail biting Yes No

f. Bedwetting Yes No

g. Getting along with friends Yes No

h. Self-help skills (dressing, bathing, etc.) Yes No

i. Understanding Directions Yes No

j. Unusual fears (describe) Yes No

_____

_____ SCHOOL AND EDUCATIONAL INFORMATION

Age began daycare/nursery or preschool _____

Age started Kindergarten _____

Does your child refuse to go to school Yes No

Does your child enjoy school Yes No

Is your child in special classes? Yes No

If yes, please specify_____

Has your child ever repeated a grade? Yes No

If yes, which grade_____ Is there any family member (sibling, parent, grandparent, etc.) who presently or in the past have (or had) learning difficulties or was in special classes? Yes No

If yes, who and what kind/type?_____

Do you feel that your child is making progress at school Yes No

Are you satisfied with the school program for your child? Yes No

Briefly describe any academic problems that your child is facing at school_____

_____

_____

Does your child face trouble in these specific learning areas:

a. Math Yes No

b. Reading Yes No

c. Writing Yes No

d. Verbal/Oral Expression Yes No

e. Understanding instructions Yes No

SOCIAL AND EMOTIONAL INFORMATION

List your child's major interest and hobbies_____

_____

_____

Is your child involved in extracurricular activities? Yes No If yes, what kind_____

Friends (how many):_____ Age range_____

Briefly describe any behavioral problems that your child is facing at home/school_____

_____

_____

Are there any past or present circumstances which you think could be related to your child's present difficulties?_____

_____

Has your child ever experienced any traumatic events (e.g., death of a close relative or

friend, accident, etc.)? Yes No

If yes, please describe _____

_____ Has your child ever had counseling, psychotherapy, or a psychological or psychiatric

evaluation? Yes No

If yes, date(s) _____

Agency or name of therapist _____

Do any family members have (or have had) a psychological disorder? Yes No

If yes, who and what kind? _____

Please put any other comments that will help us understand your child better_____

_____

_____

_____

_____

CONSENT FOR TREATMENT

I voluntarily agree to and give consent for evaluation / treatment Still Tranquility, LLC for myself and/or my family members.

Patient/Parent/Guardian Signature_____

Printed Name: _____ Date: _____

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