DZ Counseling & Neurofeedback Training Services
Child, Adolescent, Adult, Couples & Family Counseling
501 Iron Bridge Road, Suite 15, Freehold, NJ 07728
Phone: 732-866-8611 ♦ Fax: 732-303-1221 ♦ www.dz-counseling.com

Daniel Zykorie, LCSW-S
Cathy Ielpi, MA, LPC
Jason Suleski, MSW, LCSW

Intake Questionnaire – Child

(To be completed along with child 14 yrs. and older)

Please print clearly

Background Information

Date: _____/_____/_____

DOB: ___/_____/_____

Name: _____ Sex: ☐M ☐F Gender Identity: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Work Phone: _____ Email: _____

Person completing form: _____ Relationship to child _____

Child's Doctor: _____

Address: _____

City: _____State: _____ Zip: _____ Phone: _____

Who referred your child for this counseling / Neurofeedback? _____

What are your concerns or questions about your child?

_____

_____

_____

When did you first become concerned? _____

_____

What caused you to become concerned? _____

_____

What would you like to accomplish in counseling and/or from Neurofeedback?

_____

_____

Medical History

Is your child adopted? ☐Yes ☐ No

How old was mother when she became pregnant? _____

How long was the pregnancy? _____

Did the mother experience any health problems during pregnancy? (Check all that apply)

☐Inadequate weight gain ☐Excessive weight gain ☐High Blood Pressure
☐Gestational Diabetes ☐Protein in Urine ☐Other: _____

Did mother smoke during pregnancy?
☐No ☐Yes (how much) _____

Did mother drink alcohol during pregnancy?
☐No ☐Yes (how much per week) _____

Any complications during delivery? _____

_____

Did your baby have any medical problems after birth?

_____

_____

Is your child growing well? ☐Yes ☐No If no, explain:

_____

Immunizations up to date? ☐Yes ☐ No If no, explain:

_____

Allergies? ☐Yes ☐No If yes, please specify:

_____

Frequent ear infections? ☐Yes ☐No If yes, please specify:

_____

Seizures? ☐Yes ☐No If yes, please specify:

_____

Please list any hospital admissions or emergency room visits for your child:

_____	_____	_____
Date	Hospital	Reason for Admission
_____	_____	_____
Date	Hospital	Reason for Admission

Please list any medications your child takes on a regular basis and prescribing physician:

_____

_____

Has your child's hearing and vision ever been checked? ☐Yes ☐No If yes, where and what were the results?

_____

_____

Developmental History

Which of the following can your child do? Please indicate the approximate age when a child became able to do each item:

Age	Gross Motor	Age	Fine Motor	Age	Language
	Hold head up		Open hands		Smile to others
	Roll over (front to back)		Reach for objects		Coo
	Rollover (back to front)		Finger Feed		Laugh
	Sit unsupported		Pincer grasp		Babble
	Crawl		Hold cup		Wave bye-bye
	Pull to stand		Use spoon		Say dada and mama
	Walk alone		Show hand preference		Understand "no"
	Walk upstairs		Remove some clothing		Say first word
	Run		Unbutton clothing		Follow simple commands
	Pedal tricycle		Button clothes		Point to desired objects
	Skip		Zippers and snaps		Say 4 to 6 words
	Hop		Tie shoes		Say 2-word phrases
	Ride 2-wheeler		Toilet trained		Says 50 words
					Use complete sentences
					Holds conversations

How clear is your child's speech? That is, how much of your child's speech can a stranger understand?

☐ All or almost all ☐ About half ☐ Less than half

Behavioral History

How would you describe your child's personality?

As an infant or toddler: _____ As a child: _____

As a teenager: _____

How does your child get along with other children?

_____

What does your child like to do for play or free time?

_____

Does your child have difficulty with any of the following (check all that apply)?

☐*Sleeping* ☐*Eating* ☐*Tantrums* ☐*Head Banging* ☐*Hitting* ☐*Biting* ☐*Lying* ☐*Stealing* ☐*Impulsive*

☐*Hyperactive* ☐*Short Attention span* ☐*Forgetful* ☐*Aggressive* ☐*Destructive* ☐*Toileting*

☐*Other:* _____

How do you handle these behaviors?

_____

_____

_____

Educational History

Please list all schools or early intervention programs your child has attended

Year	Child's Age	School	Grade or Type of Service

Does your child have difficulties in school or receive any tutoring or extra support? If yes, please explain:

_____

Previous Evaluations/Therapies

Please list all previous evaluations/therapies your child has had:

Date	Types of Professional	Results

Family History

	Name	Age	Highest Grade Level	Occupation
Father				
Mother				
	Name	**Age/Sex**	**Any develop mental or psychiatric concerns?**	
Sibling				
Sibling				
Sibling				

Is there anybody in the family impacted by any of the following (check all that apply and for whom)

☐*Mental Retardation* ☐*Learning disability* ☐*ADHD* ☐*Anxiety* ☐ *Depression* ☐*OCD*

☐*Bipolar Disorder* ☐*Schizophrenia* ☐*Substance Use* ☐*Trauma* ☐*Attempted/Completed Suicide*

☐*Autism/PDD* ☐*Eating Disorder* ☐*Seizure Disorder* ☐*Other*_____

Who lives at home with your child? _____

_____

Form Completed By: _____Relationship to client: _____

_____ _____ _____

Client's Name Date Client's Signature (14 yrs. and older)

<u>If a client is under the age of 18, Parent's/Legal Guardian's must sign</u>: I represent that I am a parent or legal guardian of the child identified in this form. I represent that I have full or shared legal authority to consent to the child's treatment and that the consent of no other person is required.

_____ _____ _____

Parent's/Legal Guardian's Name Date Parent's/Legal Guardian's Signature

_____ _____ _____

Parent's/Legal Guardian's Name Date Parent's/Legal Guardian's Signature