# Child Assessment Intake Form

** indicates a required field*

*** Name of person(s) completing this form:**

*** Relationship to child:**

## Child's Information

**What is the child's nickname/prefered name (if any)**

*** Gender**

*** Date of Birth**

*** What led to the request for assessment?**

# Family Information

### * Child resides with: (please list all persons living in the home and their relationship to the student)

### Please indicate any family history of the following:

- [ ] Depression
- [ ] Anxiety
- [ ] Substance Abuse
- [ ] ADHD
- [ ] Learning Disabilities
- [ ] Autism Spectrum Disorder
- [ ] Suicide
- [ ] Speech/Language/Communication Disorder

### Please describe any parental history of significant mental or physical health needs

Child's Pregnancy and Birth History

### Length of pregancy:

*** Did the mother receive prenatal care?**

*** Did the child's mother use drugs, alcohol, or smoke during the pregnancy?**

- Yes
- No
- Unknown

**Were there any problems during pregnancy or delivery?**

**Were there any problems at or after birth that required medical support?**

## Childhood History

*** What language did the child learn first?**

*** What language does the child use primarily?**

# Developmental Milestones

## * Sitting up

- ○ Early
- ○ Typical (4-6 months)
- ○ Late

## * Crawling

- ○ Early
- ○ Typical (7-12 months)
- ○ Late

## * Walking

- ○ Early
- ○ Typical (10-18 months)
- ○ Late

## * First Words

- ○ Early
- ○ Typical (7-12 months)
- ○ Late

## * First Sentences

- ○ Early
- ○ Typical (2 years)
- ○ Late

**Did your child receive any early start services to address developmental delays? If yes, please describe.**

**Does the child have any medical or mental health conditions? (If yes, please include an estimate of the date the diagnosis was received).**

**Current medications**

**Does the child have any hearing or vision concerns/needs?**

### * Please indicate if the child has had any issues with the following

- [ ] Difficulty Following Multistep Directions
- [ ] Concentration
- [ ] Impulsivity
- [ ] Sleep Disturbances
- [ ] Appetite Issues (eating too much or too little)
- [ ] School Suspensions
- [ ] Grade Retention (i.e. held back)
- [ ] Difficulty controlling anger
- [ ] Anxiety
- [ ] Depression
- [ ] Suicidal Ideation
- [ ] Drug Use
- [ ] Alcohol Use
- [ ] Difficulties making friendships
- [ ] Being bullied
- [ ] Memory Issues
- [ ] Reading Difficulties
- [ ] Spelling Difficulties
- [ ] Math Difficulties
- [ ] Anger Difficulties
- [ ] None of the above

## Educational History

### Current Grade

### * Did the student attend preschool?

- ( ) Yes
- ( ) No

### Name of Elementary School(s) attended

### Name of Middle School(s) attended

### Name of High School(s) attended

### * Is the student currently receiving 504 accommodations or Special Education services via an Individualized Education Plan (IEP)?

- ○ Yes
- ○ No

### If an IEP, what disability was the student last found eligible for (if agreed upon)?

- ☐ Specific Learning Disability
- ☐ Speech or Language Impairment
- ☐ Autism
- ☐ Other Health Impairment
- ☐ Emotional Disturbance
- ☐ Intellectual Disability
- ☐ Other

### If 504, please provide a description of the disability

## Social-Emotional-Behavioral Skills

### * What are the child's strengths? (academic, social, and/or behavioral)

### * Where do you feel your child needs extra support?

### * How does the child like to spend their free time?

### * Who does the child turn to for support?

**Does the child have a history of participation in counseling for behavioral or mental health needs? If yes, please describe.**

*** How much screen time does your child engage in on a typical school day (e.g. video games, TV, computer/tablet use before or after school)?**

**What time does your child go to bed on a typical school night?**

*** Does your child typically fall asleep easily?**

- yes
- no

*** How many hours of sleep does your child typically get per night?**

## Additional Details

**Is there any other information you'd like the psychologist to know?**