

Child Intake Form

(Ages 5-13)

Name			
Date of Birth		Grade	
Mailing Address			
Phone Number Cell Phone?: Y / N			
E-mail Address			

What are the main concerns regarding your child's behaviors?

What do you hope this evaluation will help to improve?

What are your child's strengths?

Please check all that apply to your child.

My child is demonstrating difficulties with relationships in the following ways:

- | | |
|--|---|
| <input type="checkbox"/> Getting along with family | <input type="checkbox"/> Establishing and maintaining friendships |
| <input type="checkbox"/> Getting along with peers | <input type="checkbox"/> Stubbornness |
| <input type="checkbox"/> Engaging in conversations | <input type="checkbox"/> Distrustful, suspicious, secretive |
| <input type="checkbox"/> Understanding jokes | <input type="checkbox"/> Lying, sneaking |
| <input type="checkbox"/> Making eye contact | <input type="checkbox"/> Frequent arguing |
| <input type="checkbox"/> Easily embarrassed | <input type="checkbox"/> Explosive episodes |

My child is demonstrating difficulties with externalizing behaviors in the following ways:

- | | |
|---|---|
| <input type="checkbox"/> Acting violently & losing temper | <input type="checkbox"/> Abuse perpetrator |
| <input type="checkbox"/> Fire-setting | <input type="checkbox"/> Obsessions & compulsions |
| <input type="checkbox"/> Rule breaking | <input type="checkbox"/> Perfectionism |
| <input type="checkbox"/> Property Destruction | <input type="checkbox"/> Rigid & Inflexible |
| <input type="checkbox"/> Stealing | <input type="checkbox"/> Head-banging/rocking |
| <input type="checkbox"/> Cruelty to animals | <input type="checkbox"/> Skin-picking |
| <input type="checkbox"/> Running away | <input type="checkbox"/> Hair-pulling |
| <input type="checkbox"/> Risk-taking behaviors | <input type="checkbox"/> Poor frustration tolerance |
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Nightmares |

My child is demonstrating difficulties with language & learning in the following ways:

- | | |
|---|--|
| <input type="checkbox"/> Resistance to school | <input type="checkbox"/> Completing a task |
| <input type="checkbox"/> Reading, writing, & spelling | <input type="checkbox"/> Following directions |
| <input type="checkbox"/> Comprehending math concepts | <input type="checkbox"/> Poor impulse control |
| <input type="checkbox"/> Comprehending oral and/or written language | <input type="checkbox"/> Poor judgement |
| <input type="checkbox"/> Getting started on a task | <input type="checkbox"/> Poor handwriting |
| <input type="checkbox"/> Staying on task | <input type="checkbox"/> Conversations seem to be disorganized |
| | <input type="checkbox"/> Responses to questions seem to be 'off' |

My child is demonstrating difficulties with physical functioning in the following ways:

- | | |
|---|---|
| <input type="checkbox"/> Tics/twitching | <input type="checkbox"/> Sleeps too much |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sleeps too little |
| <input type="checkbox"/> Pain/body complaints | <input type="checkbox"/> Overeating |
| <input type="checkbox"/> Sensory Issues | <input type="checkbox"/> Restrictive eating |
| <input type="checkbox"/> Blank Spells | <input type="checkbox"/> Nail-biting |
| <input type="checkbox"/> Bed-wetting/Frequent urinary accidents | <input type="checkbox"/> Poor coordination |
| <input type="checkbox"/> Soiling | <input type="checkbox"/> Clumsy with hands |

Birth & Early Childhood Development History

Length of Pregnancy (in months): _____

Any illnesses or complications while pregnant? If yes, please explain: _____

Please list any medications prescribed to the mother during pregnancy: _____

Did the mother use any of the following while pregnant? (*Check all that apply*):

- | | |
|---|---|
| <input type="checkbox"/> Caffeine | <input type="checkbox"/> Prescription medication/treatment other than routine prenatal care |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Other |
| <input type="checkbox"/> Alcohol | |
| <input type="checkbox"/> Recreational Drugs | |

How was baby delivered? (*Please circle one*): vaginally cesarean section

Birth weight and length: _____

Please describe any complications experienced following the birth of the child: _____

When your child was an infant and toddler, how would you rate the following behaviors?

	Average		Moderate		Severe	
Quiet & content	1	2	3	4	5	Colicky and irritable
Very easy to feed	1	2	3	4	5	Daily feeding problems
Slept well	1	2	3	4	5	Frequent sleeping problems

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	Average		Moderate		Severe	
Usually relaxed	1	2	3	4	5	Often restless
Underactive	1	2	3	4	5	Overactive
Cuddly, easy to hold	1	2	3	4	5	Did not enjoy cuddling
Easily calmed down	1	2	3	4	5	Tantrums or Head banging
Cautious and careful	1	2	3	4	5	Accident prone & Daredevil
Coordinated	1	2	3	4	5	Uncoordinated
Enjoyed eye contact	1	2	3	4	5	Avoided eye contact
Liked people	1	2	3	4	5	Disliked contact with people

Please list any developmental delays or concerns you have noticed. _____

Birth Family History

	Birth Mother	Birth Father
Age		
Diploma or Degree		
Occupation		

Adoption History

Was the child adopted? Yes or No

From where was the child adopted? _____

At what age was the child adopted? _____

Medical History

Does your child have or has s/he ever had any of the following? (*Check all that apply*)

- | | |
|---|--|
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Head Injuries/Concussion | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> High Fever | <input type="checkbox"/> Other Illness |
| <input type="checkbox"/> Ear Infections | |

Please describe treatment given and any complications for illnesses or injuries indicated above:

Has your child ever been hospitalized? If yes, for what? _____

Describe any hearing or vision problems: _____

List any previous surgeries, child's age and length of hospitalization: _____

Is your child currently taking any medications? If yes, please list.

Medication	Dosage

Psychiatric History

Has your child been hospitalized? Participated in an outpatient program? If so, please elaborate.

Does your child demonstrate the following behaviors?

	Not at all	1-2 Days/week	3-4 Days/week	Everyday
Has thoughts of self-harm				
Feels sad, empty, hopeless				
Cries easily and frequently				
Is irritable, moody, sullen, pouts				
Has lost pleasure in activities previously enjoyed				
Sleeps too much or too little				
Seems restless				
Behaviors seemed to be slowed down; seems listless				
Fatigue/loss of energy				
Feelings of worthlessness				
Excessive or inappropriate guilt				
Negative & self-critical thoughts				
Decreased ability to think or concentrate				
Socially withdrawn & isolated				
Is indecisive & easily confused				

	Not at all	1-2 Days/week	3-4 Days/week	Everyday
Complains of stomachaches & headaches				
Feels nervous, anxious, restless, on edge				
Excessive worrying, irritable, impatient				
School refusal				
Trouble relaxing and sitting still & restlessness				
Is afraid that something 'bad' is going to happen				
Engages in repetitive behaviors to manage the worry				
Easily fatigued, sleep disturbance, muscle tension				

Has your child worked with a therapist? If so, please elaborate. _____

School History

Name of child's current school: _____

Grade: _____

Have teachers reported concerns? If yes, in what areas (*please circle*)?

Reading	Arithmetic	Social Adjustment
Writing	Attention Span	Following Directions
Spelling	Activity Level	Comprehension

Does your child have an IEP? If yes, what services is he/she provided?

Child Learning Disability Screening Questionnaire

Please rate your child on each of the symptoms listed below using the following scale:
 0=never ♦ 1= rarely ♦ 2=occasionally ♦ 3= frequently ♦ 4= very frequently ♦ N/A not applicable

Reading	Rating
Poor reader	
Does not like to read	
Makes mistakes when reading (e.g., skipping lines)	
Has problems remembering what was read	
Reverse letters when reads	
Switches letters in words when reading	
Eyes hurt or water when reading	
Tends to combine words when reading	
Has difficulty understanding the main idea	
Has difficulty understanding the important points	
Has trouble sounding out words	
Words tend to blur when reading	
Oral Expressive Language (<i>Has difficulty with...</i>)	Rating
Expressing self in words	
Getting to the point	
Answering questions people ask	
Answering questions as quickly as other students	
Asking for help when needed	
Formulating questions	
Verbally expressing thoughts	
Using a variety of vocabulary when talking	
Describing this to people	
Staying on topic when talking	
Putting events in the right order when telling stories	
Talking about things that have happened in an organized manner	
Using correct grammar when talking	
Using complete sentences when talking (speak in short, choppy manner)	
Expanding an answer or providing details when talking	
Having a conversation with someone	
Saying something another way when people do not understand what he/she said	
Getting angry or upset when people do not understand what he/she said	
Finding the right words to say in a conversation	
Providing a clear answer to a question ('off topic')	

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0=never ♦ 1= rarely ♦ 2=occasionally ♦ 3= frequently ♦ 4= very frequently ♦ N/A not applicable

Writing	Rating
Has 'messy' handwriting	
Work tends to be messy & disorganized	
Letters run into each other/no spaces between letters	
Has trouble staying within the lines	
Prefers to print rather than write in cursive	
Problems with punctuation and grammar	
Has trouble copying off the board	
Has trouble getting thoughts from brain to paper	
Can tell a story, but cannot write one	
Writes in shorty, choppy sentences	
Has trouble expanding an answer or providing details	
Has trouble putting words in the right order when writing	
Receptive Language (<i>difficulty with...</i>)	Rating
Understanding people and tends to give the wrong answer in conversation	
Understanding directions, following a lecture,	
Keeping up with what is being said in a conversation	
Remembering what people have said to him/her (people have to repeat what they say)	
Understanding the meaning of words	
Understanding new ideas	
Seems to be confused or 'lost' in a conversation	
Needs information 'broken down' to simplistic structures	
Social Skills	Rating
Has few or no friends	
Has trouble reading body language and facial expressions	
Tends to get into trouble with friends, teachers, other adults	
Feels uncomfortable around people he/she does not know well	
Is teased by others	
Friends do not call and ask to get together with him/her	
Does not get together with others outside of school	
Body Awareness/Spatial Awareness	Rating
Confuses/has difficulty with left from right	
Problems writing within the lines	
Difficulty maintaining balance	
Clumsy & uncoordinated	
Problems with hand-eye coordination	
Difficulty with concepts such as up, down, over, under	
Often bumps into things when walking	