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Child Intake Form

DATE OF INTAKE: _____

NAME: _____ SEX: _____

DATE OF BIRTH: _____ GRADE: _____

SCHOOL: _____

HOME ADDRESS: _____

_____

HOME PHONE NUMBER: _____

NAME OF INFORMANT(S):_____

RELATIONSHIP TO CHILD:_____

CELLULAR PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

BETTER WAY TO REACH YOU? _____

I. REASON FOR REFERRAL:

Who referred you to us?_____

What do you perceive the problem to be? _____

_____

_____

_____

What would you like us to help you determine:_____

_____

_____

_____

Why now?_____

_____

II. BACKGROUND INFORMATION

A. General background history

Name of Mother: _____

Education: _____

Profession: _____

Name of Father:_____

Education: _____

Profession: _____

List family members (siblings, other(s) living with child):

Relationship to child	Age	Gender	Lives at home?

B. Other pertinent background history

Parents' marital status? _____

If parents are not married, then:

Do you have a significant other? _____

Does s/he live with the family? _____

How do(es) the child(ren) get along with him/her?_____

_____

_____

If parent divorced or widowed:

When (how old was the child)? _____

Who has custody of the child? _____

Relationship with non-custodial parent: (How often does your child see him/her?) _____

_____

Languages spoken other than English:_____

What do you consider your (your child's) main language? _____

C. Developmental History:
Pregnancy with child (any complications?):

_____

_____

Delivery and perinatal complications (at term, induced, C-section?)**:**

_____

_____

How was your child as a baby?_____

_____

Developmental Milestones: (comment on any problems or delays)

1. Motor _____-_____
2. Language _____
3. Toilet trained (At what age? Accidents after toilet trained?) _____

_____

D. Medical History:

1. Hospitalizations ?_____

_____

2. Chronic illnesses (asthma, diabetes, allergies, etc.)? _____

_____

3. Allergies _____
4. Ear infections (When? Frequency?): _____

_____

5. Other illnesses: _____

_____

6. Accidents: _____
   When? _____
   How did it happen? _____

_____

   Loss of consciousness? _____ For how long?_____

History of past and present medications (do not include regular antibiotics for colds, etc.)

Medicine	Indication	Dosage	Duration of Treatment	Side Effects

E. School Information

Previous schools? _____

_____

_____

Why did your child change school? _____

_____

When did school problems start? _____

Who first noticed problems?_____

What kind of problems is your child having in school? _____

_____

What areas are the most difficult for him/her?_____

_____

Did your child have a difficult time learning to read?_____

What are his grades? _____

Special placement in school? _____

Has your child has been evaluated in the past? _____

Reasons for evaluation: _____

_____

Has your child received tutoring in the past? For what? For how long?: _____

_____

_____

Did it help or is it helping? _____

_____

F. Social Life:

1. Does your child have many friends?_____
2. Does s/he fight a lot with them? _____
3. What kind of activities does your child do with her/his friends?_____

_____

4. How does s/he get along with other children at school ?_____

_____

6. What does your child do for fun? (activities, hobbies, sports, etc.)

_____

_____

_____

Additional information that could help us understand your child better:

_____

_____

_____

_____

Do you have any questions for us?_____

_____

_____

_____

_____