



Referred by: _____

Are the requested services for: (please indicate request):

| | |
|--------------------------|-----------------------|
| <input type="checkbox"/> | CWS (current or past) |
| <input type="checkbox"/> | Adoption |
| <input type="checkbox"/> | Cultivate |

Child's Name: _____ Parent(s) Name(s): _____

DOB: _____ Gender: ☐ M or ☐ F Re above: ☐ Bio ☐ Step ☐ Foster ☐ Kinship ☐ Adoptive

Address: _____
(Street) (City) (Zip)

Phone: Home: _____ Cell: _____ Other: _____

Email Address: _____

Marital Status (parents): _____ Ethnicity/Race: _____

Language(s) spoken: _____

School Attending: _____ Grade: _____

Hand used for writing: ☐ Left or ☐ Right Glasses or hearing aids: _____

Medical/psychological diagnosis, physician, and date (if any): _____

Briefly describe the problems or symptoms and when they began: _____

What specific questions would you like answered? _____

Primary:

Health Insurance: _____ Subscriber Name: _____

Subscriber ID #: _____ Subscriber DOB: _____

Secondary:

Health Insurance: _____ Subscriber Name: _____

Subscriber ID #: _____ Subscriber DOB: _____

Responsible party for payment of services: _____

***NOTE: Services are free for foster and adoptive families. The general public may access the same services fee-for-service, which supports Whole Foundation. Upon request, we provide a superbill for self-submission. Most insurers do not cover qEEG brain mapping or neurofeedback.**

This form was completed by: Parents: ☐ Y or ☐ N Other: _____
If not completed by the parent, please provide the following information:

Name: _____ Address: _____

Phone: _____ Relation: _____

Family History

The following questions deal with the child's BIOLOGICAL family members: Mother

What is the mother's name (including maiden name): _____

Is she alive? ☐ Yes ☐ No If not, list cause of death: _____

Mother's occupation: _____

Mother's level of education obtained: _____

Mother's hobbies: _____ Does

the mother have a known/suspected learning disability? ☐ Yes ☐ No

Briefly describe the mother's health history: _____

Father

What is the father's name: _____

Is he alive? ☐ Yes ☐ No If not, list cause of death: _____

Father's occupation: _____

Father's level of education obtained: _____

Father's hobbies: _____

Does the father have a known/suspected learning disability? ☐ Yes ☐ No

Briefly describe the father's health history: _____

Child currently lives with

Please check which one: ☐ Step-parent ☐ Adopted parent ☐ Kinship parent ☐ Foster parent

Name(s): _____

Are they alive? ☐ Yes ☐ No If not, list cause of death: _____

Occupation: _____

Highest level of education obtained: _____

Hobbies: _____

Do they have a known/suspected learning disability? ☐ Yes ☐ No

Briefly describe health history: _____

When the child was born, what was the mother's age? ____ Father's age? ____

How many brothers are there? ____ How many sisters are there? ____

Where is child in the birth order? _____

Are there unusual issues associated with any of the siblings? ☐ Yes ☐ No

If yes, please describe: _____

Family Life

Was the child adopted or fostered (circle one)? ☐ Yes ☐ No At what age? _____

Early History

Was child born: ☐ On time ☐ Late ☐ Prematurely (# of weeks ____)

Weight at birth: ____ lbs ____ ozs Mother's weight gain during pregnancy: ____ lbs

Where was child born: _____

Was mother induced with Pitocin? ☐ Yes ☐ No

Was birth by Cesarean? ☐ Yes ☐ No ☐ Planned ☐ Emergency

Check all that applied to the mother while she was pregnant:

☐ Accident ☐ Alcohol use ☐ Gestational Diabetes ☐ Poor nutrition

☐ Cigarette smoking ☐ Drug use ☐ Psychological problems ☐ Illness

Other issues: _____

List all the medications (prescription or over the counter) the mother took while pregnant:

During her pregnancy, did the mother live near a polluted area (toxic waste dump) or hazardous area (nuclear plant, industrial area, pesticide sprayed area, etc.)? ☐ Yes ☐ No

If yes, describe: _____

Were there any issues associated with child's birth (e.g. oxygen deprivation, unusual birth position, etc.) or the period immediately following the birth (e.g. need for oxygen, special equipment used, convulsions, illness, etc.)? ☐ Yes ☐ No

Describe: _____

Rate your child's development progress:

Walking: _____

Language: _____

Toilet Training: _____

Overall development: _____

Medical History of Child (or self)

Any major medical conditions: _____

Does the child have epilepsy or a seizure disorder? ☐ Yes ☐ No Ever have a head injury? ☐ Yes ☐ No

If yes, please describe: _____

Describe all hospitalizations (Include purpose, length of stay, and location):

Do or have any of the following conditions exist? (Check all that apply)

☐ Attention problems ☐ Head injury ☐ Speech delay ☐ Hearing problems

☐ Hyperactivity ☐ Clumsiness ☐ Vision problems ☐ Frequent ear infections

☐ Learning delay ☐ Development delay ☐ Muscle tightness or weakness

Other problems: _____

List any medications the child (or you) currently take(s) (prescription or over the counter):

| Medication | Dosage | Frequency Taken | Date began Taking | Prescribed by | Prescribed for |
|------------|--------|--------------------|----------------------|---------------|----------------|
| | | | | | |
| | | | | | |
| | | | | | |

Medical Information

Primary care physician information:

Name: _____ Clinic: _____

Address: _____ Phone: _____

Up to date with immunizations and examinations: ☐ Yes ☐ No

Is there a treating psychologist/psychiatrist?

Name: _____ Clinic: _____

Address: _____ Phone: _____

Start date of therapy: _____ Frequency of therapy: _____

Reason for therapy: _____

Has the child had a previous psychological/neuropsychological evaluation?

If yes, please list the name and address of the psychologist and date administered:

* Please provide a copy of the report at your intake appointment

Medical Testing

Check all the medical tests completed recently (within the past year) and report any abnormal findings:

☐ Angiography ☐ Blood work ☐ CT scan ☐ EEG ☐ MRI/fMRI ☐ PET/SPECT

Other test(s) _____

Please check all that existed in close biological family members (parents, siblings, grandparents, aunts, uncles, etc.). Note who it was and describe the issue where indicated:

☐ Epilepsy or seizures _____

☐ Learning disabilities _____

☐ Global Developmental Delay _____

☐ Speech or language disorder(s) _____

Neurological or Psychiatric Disorders

☐ Bipolar disorder _____

☐ Depression _____

☐ Personality disorder _____

☐ Other psychiatric disorders _____

At any time, was the child exposed to toxic, hazardous, noxious or other dangerous or unusual substances? (ex. lead, mercury, radiation, solvents, pesticides, chemicals, etc.)? ☐ Yes ☐ No If yes, list: _____

Substance Use History of Child (or Self)

Alcohol

Has the child (or have you) used alcohol? ☐ Yes ☐ No

Drugs

Please check all drugs currently using or have used in the past:

| | <i>Presently using</i> | <i>Used in the past</i> | <i>Prenatal Exposure</i> |
|---|------------------------|-------------------------|--------------------------|
| <input type="checkbox"/> Amphetamines | _____ | _____ | _____ |
| <input type="checkbox"/> Barbiturates | _____ | _____ | _____ |
| <input type="checkbox"/> Cocaine or crack | _____ | _____ | _____ |
| <input type="checkbox"/> Hallucinogens | _____ | _____ | _____ |
| <input type="checkbox"/> Marijuana | _____ | _____ | _____ |
| <input type="checkbox"/> Opiates/Narcotics (Heroin) | _____ | _____ | _____ |
| <input type="checkbox"/> PCP | _____ | _____ | _____ |

List any other drugs, including designer and “non-harmful” or “non-addictive” drugs:

Do you consider the child dependent on any of the above drug(s)? ☐ Yes ☐ No

Do you think the child is dependent on any prescription drug(s)? ☐ Yes ☐ No

Check all that apply:

☐ Has the child (or have you) been through drug withdrawal? ☐ Used IV drugs? ☐ Drug treatment?

Personal History

Education

Describe the child's performance as a student: ☐ A & B's ☐ B & C's ☐ C & D's ☐ D & F's

Please provide any additional/helpful comments about academic performance: _____

Best subject in school: _____ Weakest: _____

Has the child (or have you) been held back a grade? ☐ Yes ☐ No If yes, which grade: _____

Is the child (or were you) in special classes/received special education services? ☐ Yes ☐ No

Does the child have a current IEP? ☐ Yes ☐ No

**If yes, please bring a copy of current IEP to intake meeting.*

Recreation/Exercise

Briefly list the types of recreation the child (or you) enjoy(s): _____

Child's (or self) Occupational History/School

Current job title: _____ How long at job? _____

Current job responsibilities: _____

Prior jobs and time spent at them: _____

Child's (or self) Dietary History

Briefly list the types of foods the child (or you) enjoy(s): _____

Typical breakfast: _____ Typical snacks: _____

Typical lunch: _____

Typical dinner: _____

How many servings of fruits and vegetables on a typical day? _____

Child's (or self) Sleep History

Briefly list the quality and quantity of your Child's (or your) sleep: _____

Typical bedtime: _____ Typical wake time: _____

SYMPTOM SURVEY

Please place a check on the line next to each applicable symptom. Check the side marked "NEW" if the symptom has been present for 6 months or less. Check the side marked "OLD" if the symptom has been present for more than 6 months.

Problem Solving

- | | |
|---|---|
| <input type="checkbox"/> Difficulty figuring out how to do new things | <input type="checkbox"/> Difficulty figuring out how to do things |
| <input type="checkbox"/> Difficulty planning ahead | <input type="checkbox"/> Difficulty thinking as quickly as needed |
| <input type="checkbox"/> Difficulty doing things in the right order | <input type="checkbox"/> Changing a plan or activity |
| <input type="checkbox"/> Figuring out problems most other people can do | <input type="checkbox"/> Difficulty doing more than one thing |
| <input type="checkbox"/> Difficulty verbally describing the steps involved in doing something | |
| <input type="checkbox"/> Difficulty completing an activity in a reasonable amount of time | |
| <input type="checkbox"/> Difficulty switching from one activity to another activity | |
| <input type="checkbox"/> Easily frustrated | |

Other problem solving difficulties: _____

Speech, Language and Math Skills

- | | |
|--|---|
| <input type="checkbox"/> Difficulty finding the right words to say | <input type="checkbox"/> Odd or unusual speech sound |
| <input type="checkbox"/> Difficulty understanding what others are saying | <input type="checkbox"/> Difficulty with math |
| <input type="checkbox"/> Unable to speak | <input type="checkbox"/> Difficulty staying with one idea |
| <input type="checkbox"/> Slurred speech | <input type="checkbox"/> Difficulty spelling |
| <input type="checkbox"/> Difficulty understanding what was read | |
| <input type="checkbox"/> Difficulty writing letters or words (not due to motor problems) | |

Other speech, language, or math problems: _____

Nonverbal Skills

- | | |
|--|---|
| <input type="checkbox"/> Difficulty telling right from left | <input type="checkbox"/> Problems drawing or copying |
| <input type="checkbox"/> Difficulty recognizing objects or people | <input type="checkbox"/> Decline in musical abilities |
| <input type="checkbox"/> Slow reaction time | <input type="checkbox"/> Difficulty dressing |
| <input type="checkbox"/> Difficulty doing things the child should automatically be able to do (e.g. brushing teeth, etc.) | |
| <input type="checkbox"/> Problems finding way around places the child has been to before | |
| <input type="checkbox"/> Unaware of things on one side of the body (<input type="checkbox"/> right <input type="checkbox"/> left) | |

Other nonverbal issues: _____

Concentration and Awareness

- | | |
|---|---|
| <input type="checkbox"/> Highly distractible | <input type="checkbox"/> Loses train of thought easily |
| <input type="checkbox"/> Problems concentrating | <input type="checkbox"/> Becomes easily confused or disoriented |
| <input type="checkbox"/> Blackout spells (fainting) | <input type="checkbox"/> Mind goes blank |
| <input type="checkbox"/> Doesn't feel very alert or aware of things | |

Other concentration or awareness issues: _____

Memory

- | | |
|---|--|
| <input type="checkbox"/> Forgetting where things are left (books, etc.) | <input type="checkbox"/> Forgetting names |
| <input type="checkbox"/> Forgetting what they should be doing | <input type="checkbox"/> Forgetting where they are |
| <input type="checkbox"/> Forgetting recent events (such as the last meal) | <input type="checkbox"/> Forgetting past events (months/years) |
| <input type="checkbox"/> Need hints to remember things | <input type="checkbox"/> Forgetting the order of things |
| <input type="checkbox"/> Forgetting facts | <input type="checkbox"/> Forgetting how to do things |

Other memory issues: _____

Motor Coordination

- | | |
|--|--|
| <input type="checkbox"/> Fine motor control problems | <input type="checkbox"/> Weakness on one side of body |
| <input type="checkbox"/> Difficulty walking or bumping into things | <input type="checkbox"/> Tremor or weakness |
| <input type="checkbox"/> Muscle tics or strange movements | <input type="checkbox"/> Writing is very small |
| <input type="checkbox"/> Writing is very large | <input type="checkbox"/> Walking more slowly than other people |
| <input type="checkbox"/> Feeling stiff | <input type="checkbox"/> Balance problems |
| <input type="checkbox"/> Difficulty starting to move | <input type="checkbox"/> Muscles tire quickly |

Other motor or coordination issues: _____

Sensory

- | | |
|--|--|
| <input type="checkbox"/> Loss of feeling or numbness | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Tingling or strange skin sensations | <input type="checkbox"/> See "stars" or flashes of light |
| <input type="checkbox"/> Difficulty telling hot from cold | <input type="checkbox"/> Losing hearing |
| <input type="checkbox"/> Problems seeing on one side | <input type="checkbox"/> Difficulty tasting food |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Difficulty smelling |
| <input type="checkbox"/> Blank spots in vision | <input type="checkbox"/> Smelling strange odors |
| <input type="checkbox"/> Need to squint or move closer to see clearly | <input type="checkbox"/> Brief periods of blindness |
| <input type="checkbox"/> Difficulty looking quickly from one objects to another object | |
| <input type="checkbox"/> Ringing in my ears or hearing strange sounds | |

Other sensory issues: _____

Physical

- | | |
|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of bowel control |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Excessive tiredness |
| <input type="checkbox"/> Nausea or vomiting | |

Other physical issues: _____

Behavior

Check all that apply to your child/self in the past 6 months:

- ☐ Sadness or depression
- ☐ Anxiety or nervousness
- ☐ Sleeping problem (Falling asleep: ☐ Staying asleep: ☐)
- ☐ Become angry more easily
- ☐ Euphoria (feeling on top of the world)
- ☐ Much more emotional (cry more easily)
- ☐ Feel as if I just don't care anymore
- ☐ Doing things automatically (without awareness)
- ☐ Less inhibited (do things I would not do before)
- ☐ Difficulty being spontaneous
- ☐ Change in eating habits

Other recent changes in behavior/personality: _____

Check the answer that best fits:

Overall, symptoms have developed:

- ☐ Slowly ☐ Quickly

Symptoms occur:

- ☐ Occasionally ☐ Often

Over the past 6 months symptoms have:

- ☐ Stayed the same ☐ Worsened