Dear Parent/Guardian,

Please fill out this form in as much detail as possible. We appreciate your taking time to provide us with this information which will help us understand your concerns and make an accurate diagnosis.

CHILD INTAKE/HISTORY

Name of person completing the form _____
Last *First*

Relationship to the Child_____

Child's Name_____
Last *First* *Middle Initial*

Age_____Date of Birth___/___/_____Place of Birth_____
(mm/dd/yyyy) *City/US State/Country*

Grade_____School_____

Home Street Address_____

City_____State_____Zip_____

Home Phone Number_____Alternate Phone Number_____

Emergency Contact Person's Name_____Phone_____

FAMILY INFORMATION

Mother's Name_____

Age_____Date of Birth___/___/_____Occupation:_____
(mm/dd/yyyy)

Education _____

Phone (Home)_____(Work)_____(Cell)_____

Email Address_____

Age at time of Marriage_____Age at time of Birth of Child_____

Father's Name_____

Age_____Date of Birth___/___/_____Occupation:_____
(mm/dd/yyyy)

Education_____

Phone (Home)_____(Work)_____(Cell)_____

Email Address_____

Age at time of Marriage_____Age at time of Birth of Child_____

*If parents living apart, other parent's: Home Phone Number_____

Street Address_____

City_____State_____Zip_____

Household Composition

Name (Last, First)	**Age**	**Relationship**	**Education**	**Occupation**

Family Members/Significant Others not in household

Name (Last, First)	**Age**	**Relationship**	**Phone#**	**Occupation**

How does your child get along with**:**

Mother?_____Father?_____ Sister(s)? _____

Brother(s)?_____Other family members? _____

Is child living with both biological parents? ☐ Yes ☐ No

If not, please explain_____

_____

MEDICAL AND HEALTH INFORMATION

Current Height_____ Current Weight_____

Has your child had any surgery, serious illnesses or accidents? ☐ Yes ☐ No

Does your child have allergies? (Environmental or food allergies) ☐ Yes ☐ No

Does your child have asthma or any other respiratory problems? ☐ Yes ☐ No

Does your child have any medical conditions? ☐ Yes ☐ No

If you answered yes to any of the above questions, please explain: _____

_____

_____

Does your child take any medications regularly? ☐ Yes ☐ No

If yes, please list Name, dose, frequency):

_____

_____

Has your child ever been examined by:

Ear, Nose, and Throat Doctor? ☐ Yes ☐ No

Neurologist? ☐ Yes ☐ No

Psychologist? ☐ Yes ☐ No

Other Medical Specialist ☐ Yes ☐ No

If yes, please explain reason for visit and outcome: _____

_____

Please give place and dates of any previous evaluations or therapy:

Hearing: _____

Vision: _____

Physical Therapy: _____
Occupational Therapy: _____

Speech/Language Therapy: _____

Psychotherapy: _____

Other: _____

Has your child's hearing ever been tested? ☐ Yes ☐ No

Results: ☐ Normal ☐ Hearing Impairment (please explain) _____

Does your child have a history of ear infections?

☐ None ☐ Rarely ☐ 1-2 times /year ☐ 3-4 times /year ☐ 5 or more times/year

What treatment was provided for your child's ear infections? _____

Has your child ever had tubes in his or her ears or other ear surgery? ☐ Yes ☐ No

If yes, please explain_____

Does your child have any vision problems? ☐ Yes ☐ No

If yes, please explain_____

How would you describe your child's overall health? ☐ Good ☐ Poor

Pediatrician's name _____

Practice_____ Phone number:_____

PRENATAL HISTORY

While pregnant, did mother have:

a. High blood pressure ☐ Yes ☐ No

b. Excessive Vomiting ☐ Yes ☐ No

c. Bleeding or spotting ☐ Yes ☐ No

d. Kidney Disease ☐ Yes ☐ No

e. Toxemia ☐ Yes ☐ No

f. Gestational diabetes ☐ Yes ☐ No

Threatened Miscarriage ☐ Yes ☐ No

g. German Measles (Rubella) ☐ Yes ☐ No

h. Illness other than cold or flu ☐ Yes ☐ No

i. Hospitalization Required ☐ Yes ☐ No

j. Premature labor ☐ Yes ☐ No

Was there any substance/alcohol abuse? ☐ Yes ☐ No

If yes, please explain_____

_____

Did mother take any medications during pregnancy ☐ Yes ☐ No

If yes, please explain_____

_____

BIRTH HISTORY

Where was baby born: _____

Was labor induced: ☐ Yes ☐ No

Was labor helped by medication: ☐ Yes ☐ No

Duration of labor: _____

Was baby born early: (less than 38 weeks) ☐ Yes ☐ No

Was baby born late (after 42 weeks) ☐ Yes ☐ No

What was the method of delivery?

☐ Spontaneous vaginal ☐ Forceps

☐ Breech ☐ Caesarean

Reason_____

Birth weight of baby:_____

During hospital stay, did baby have any of the following:

a. Jaundice ☐ Yes ☐ No
b. Antibiotic treatment ☐ Yes ☐ No
c. Rash ☐ Yes ☐ No
d. Blue spells ☐ Yes ☐ No
e. Convulsions ☐ Yes ☐ No
f. Remain in hospital longer than mother ☐ Yes ☐ No
g. Incubator Care ☐ Yes ☐ No
h. Infection ☐ Yes ☐ No

DEVELOPMENTAL HISTORY

Approximate age at which your child reached these developmental milestones:

	Age	**If exact age not known; it occurred**		
		Early	**Late**	**Normal**
Hold up head				
Roll over				
Sit unsupported				
Respond to Own Name				
Crawled				
Stand alone				
Walk				
Talk				
Toilet train				
Feed her/himself				
Dress her/himself				
Jump				

Ride a Tricycle				
Read				
Throw & Catch a Ball				
Name Colors				

Please mark any areas which constitute a problem for your child:

a. Eating ☐ Yes ☐ No
b. Sleeping ☐ Yes ☐ No
c. Nightmares ☐ Yes ☐ No
d. Thumb sucking ☐ Yes ☐ No
e. Nail biting ☐ Yes ☐ No
f. Bedwetting ☐ Yes ☐ No
g. Getting along with friends ☐ Yes ☐ No
h. Self-help skills (dressing, bathing, etc.) ☐ Yes ☐ No
i. Understanding Directions ☐ Yes ☐ No
j. Unusual fears (describe) ☐ Yes ☐ No

_____

_____

SCHOOL AND EDUCATIONAL INFORMATION

Age began daycare/nursery or preschool _____

Age started Kindergarten _____

Does your child refuse to go to school ☐ Yes ☐ No

Does your child enjoy school ☐ Yes ☐ No

Is your child in special classes? ☐ Yes ☐ No

If yes, please specify_____

Has your child ever repeated a grade? Yes No

If yes, which grade_____

Is there any family member (sibling, parent, grandparent, etc.) who presently or in the past have (or had) learning difficulties or was in special classes? ☐ Yes ☐ No

If yes, who and what kind/type?_____

Do you feel that your child is making progress at school ☐ Yes ☐ No

Are you satisfied with the school program for your child? ☐ Yes ☐ No

Briefly describe any academic problems that your child is facing at school_____

_____

_____

Does your child face trouble in these specific learning areas:

a. Math ☐ Yes ☐ No
b. Reading ☐ Yes ☐ No
c. Writing ☐ Yes ☐ No
d. Verbal/Oral Expression ☐ Yes ☐ No
e. Understanding instructions ☐ Yes ☐ No

SOCIAL AND EMOTIONAL INFORMATION

List your child's major interest and hobbies_____

_____

_____

Is your child involved in extracurricular activities? ☐ Yes ☐ No If yes, what kind_____

Friends (how many):_____ Age range_____

Briefly describe any behavioral problems that your child is facing at home/school_____

_____

_____

Are there any past or present circumstances which you think could be related to your child's present difficulties?_____

_____

Has your child ever experienced any traumatic events (e.g., death of a close relative or friend, accident, etc.)? ☐ Yes ☐ No

If yes, please describe _____

_____

Has your child ever had counseling, psychotherapy, or a psychological or psychiatric evaluation? ☐ Yes ☐ No

If yes, date(s) _____

Agency or name of therapist _____

Do any family members have (or have had) a psychological disorder? ☐ Yes ☐ No

If yes, who and what kind? _____

Please put any other comments that will help us understand your child better_____

_____

_____

_____

_____

CONSENT FOR TREATMENT

I voluntarily agree to and give consent for evaluation / treatment Still Tranquility, LLC for myself and/or my family members.

Patient/Parent/Guardian Signature_____

Printed Name: _____ Date: _____