



CHILD/ADOLESCENT INTAKE FORM

(This form should be updated if any information changes. Please complete this **Intake Form** along with the **Developmental History Questionnaire**.)

Today's Date: _____
Month Day Year

PATIENT INFORMATION

****ARE YOU A LEGAL GUARDIAN OR CUSTODIAL PARENT OF THE CHILD BELOW? ****
 IF NOT, FORWARD THIS FORM TO APPROPRIATE PERSON.

Child's Name: _____ **Child's SS Number:** _____
First Middle Last

Date of Birth: _____ **Age:** _____ **Sex:** M F

Race (check all that apply): Asian American Indian Black Hispanic/Latino White Native Hawaiian Other _____

School: _____ **Grade:** _____

Name of Parent/Legal Guardian: _____ **Parent/Guardian's SS Number:** _____
Month/Day/Year

Home Address: _____
Street City State Zip Code

Home Phone: (____) _____-____ **Parent Cell Phone:** (____) _____-____ **Parent Work Phone:** (____) _____-____

OTHERS LIVING IN PATIENT'S HOME	DATE OF BIRTH	RELATIONSHIP TO PATIENT (mother, brother, stepsister, grandfather, etc.)

Other Parent's Name: _____ **Other Parent's Phone:** (____) _____-____

Other Parent's Address (If Different): _____
Street City State Zip Code

If Divorced, Does Other Parent Have: N/A Sole Custody Shared Custody Visitation Supervised Visitation No Visitation Rights

Relative not Living with Child: _____ **Phone:** (____) _____-____

Name of Emergency Contact: _____ **Phone:** (____) _____-____

GUARANTOR INFORMATION (THIS SECTION MUST BE COMPLETED BEFORE SUBMISSION)

Name of Responsible Legal Party/Guarantor: _____
First Middle Last

Guarantor's Relationship to Patient: _____ **Guarantor's Social Security Number:** _____-____-____

Guarantor's Date of Birth: _____ **Age:** _____ **Gender:** M F
Month Day Year

Guarantor's Address: _____
Street Apt. No. City State Zip

Guarantor's Home Phone: (____) _____-____ **Guarantor's Mobile Phone:** (____) _____-____

Guarantor's Employer's Name: _____ **Guarantor's Work Address:** _____
Street City State Zip

Guarantor's Work Phone: (____) _____-____

REFERRAL SOURCE

How did you hear about us?

SERVICES REQUESTED

Please indicate the type of services you are interested in (check all that apply):

- Psychological Testing
 Individual Treatment/Counseling
 Family Therapy
 Diagnostic Clarification
 Learning Assessment
 Personality Assessment
 Court, Legal, or Custody Issues
 Other _____

Please describe your primary reason for seeking services. _____

HEALTH PROVIDER INFORMATION

Patient's Physician _____ **Physician's Address:** _____
Street City State Zip Code

Describe any medical health problems your child/adolescent currently has. _____

CURRENT SYMPTOMS

Rate the degree to which your children/adolescent has experienced the following symptoms and how long each has occurred.

0 = None, Not at All 1=Mild, Rarely a Problem 2=Moderate, Sometimes It's Difficult 3=Severe, I Can Barely Stand It

Symptom	0-3	How Long?
Prolonged Sadness or Depression		
Loss of Energy		
Social Withdrawal/Avoiding Interaction with Others		
Sleeping Too Much/Sleeping Too Little <i>(circle one)</i>		
Negative View of Future/Hopelessness		
Weight Loss/Gain <i>(circle one)</i>		
Difficulty Making Decisions		
Appetite Increase/Decrease <i>(circle one)</i>		
Excessive Joy or Grand Feelings		
Risky Behaviors (splurges, drive fast, stealing) <i>(circle)</i>		
Racing Thoughts		
Pressure to Talk More than Usual		
Abnormally High Physical Activity or Energy		
Prolonged Anxiety/Nervousness		
Fear of Being Criticized in Public or Judged		
Muscle Tension		
Forgetfulness (losing things, forget appointments) <i>(circle)</i>		
Difficulty Relaxing		
Panic or Anxiety Attacks		
Nightmares		
Memories of Traumatic Event(s)		
Bedwetting/Refusal to Sleep Alone <i>(circle all that apply)</i>		
Fear of Objects/Situations/Crowds <i>(circle all that apply)</i>		
Constant and Disturbing Worries		
Rituals-Compulsions (counting, ordering, echoing) <i>(circle)</i>		
Developmental Delay (speech, motor, social skills) <i>(circle)</i>		
Math/Reading/Writing Problems <i>(circle all that apply)</i>		
Failing Grades/Skipping School <i>(circle all that apply)</i>		

Symptom	0-3	How Long?
Alcohol Misuse		
Drug Misuse		
Oppositional and Defiant Attitudes		
Decreased Academic Performance		
Conflict (parents, siblings, teachers) <i>(circle)</i>		
Lack of Friends/Negative Friends <i>(circle)</i>		
Sexual Acting Out		
Hallucinations (hearing voices, seeing things) <i>(circle)</i>		
Physical Violence/Aggression		
Suspicious Thoughts/Difficulty Trusting Others		
Temper Problems/Rage		
Physical Problems that Increase with Stress		
Fear of Having a Disease		
Short Attention Span		
Difficulty Completing Tasks		
Poor Organization		
Difficulty Following Directions		
Difficulty Sitting Still/Restlessness		
Excessive Talking		
Not Thinking Ahead about Consequences		
Legal Problems/Probation <i>(circle those that apply)</i>		
Twitches/Tics <i>(circle those that apply)</i>		
Worry about Gaining Weight/Restricting Calories		
Inducing Vomiting/Misuse of Laxatives <i>(circle)</i>		
Self-Mutilation/Cutting		
Side Effects from Medication(s)		
Other:		
Other:		

INSURANCE AND WORK INFORMATION

A copy of the patient's insurance card(s) is(are) required to confirm your insurance benefits and file claims. Please bring all active insurance card(s) when you return this form.

Do you plan to use insurance? Yes No **If yes, please complete information below using your insurance card(s).**

PRIMARY Insurance Company: _____

Name of Insured on Card: _____
First Middle Last

Group Number: _____ **Member Number:** _____

SECONDARY Insurance Company (if applicable): _____

Name of Insured on Card: _____
First Middle Last

Group Number: _____ **Member Number:** _____

Who is Responsible for Payment of Services? _____
First Middle Last

Relationship of Responsible Party to Patient: _____

Employer and Address: _____
Company Street City State Zip

Landlord: _____ **Phone #:** (____) ____-____

The undersigned hereby authorizes the release of any information relating to all claims for the benefits submitted on behalf of his or her child/adolescent. I further expressly agree and acknowledge that my signature on this document authorizes my child's provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____, **hereby authorize** _____
Name of Parent/Guarantor Name of Insurance Company

to pay and hereby assign directly to Family Psychological Center all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred, including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services, and I hereby authorize the release of my dependent's pertinent healthcare information to insurance carriers. I understand and agree that I am ultimately responsible for the balance of my dependent's account, regardless of insurance status. I further acknowledge that any insurance benefits, when received by and paid to Family Psychological Center, P.A. will be credited to my account, in accordance with the above said assignment.

I have read all the information on these sheets and have completed all of the answers that apply to me and my dependent. **I ALSO CERTIFY THAT I AM THE LEGAL GUARDIAN OF THE CHILD/ADOLESCENT AND HAVE FULL LEGAL AUTHORITY TO MAKE HEALTHCARE DECISIONS FOR THE DEPENDENT.** I certify this information is true and correct to the best of my knowledge. I will notify this office of any changes in the above information, including the dependent's address, my employment, any and all contact information, or changes in guardianship/parental custody of the dependent.

Signature of Parent/Guarantor

Printed Name of Parent/Guarantor

Date

NOTICE OF OFFICE POLICIES FOR CHILD AND ADOLESCENT PATIENTS

CONFIDENTIALITY

Confidentiality is a fundamental priority at FPC, P.A. The information your child discloses to his or her therapist remains confidential except when your child provides assent to release the information AND you provide signed authorization to release it (such as to your physician) or when legal or ethical principles apply. Confidentiality must be breached if any form of abuse involving a child, elder, or other incapacitated person is disclosed. Other instances include suicidal intentions, a specific harm against another person, or a court order. You should openly verbalize any concerns about confidentiality with your child's treatment professional. By signing below, you acknowledge receiving a copy of the "Patient Notice of Privacy Practices" from the Family Psychological Center, P.A. Which can be obtained from our office or our website at www.fpcharrison.com.

In the case of child and adolescent treatment, the legal guardian or parent usually has a legal right to access treatment information. However, one key ingredient in successful therapy is a zone of privacy. Although children and adolescents will be told at the outset that serious threats of harm to self or others cannot be kept confidential, they must otherwise have confidence that their therapy conversations will remain private before they will consider disclosing their deeply personal concerns and issues with their therapist. Few things carry more potential to disrupt treatment than the child or adolescent fearing or finding out that information was shared without his or her knowledge. If serious threats of harm or safety arise during therapy, regardless of whether a minor assents to have information disclosed to a parent to protect their safety, it makes both clinical and ethical sense to tell the child/adolescent—beforehand, if possible—what information needs to be shared, and when. Ideally, the child/adolescent would be present in the room for such conversations. Finally, in some cases, your child's therapist may believe strongly that revealing confidential information to a parent or others could harm your child or be destructive to his or her treatment. A therapist's refusal to disclose in such a case, even in the face of a parent's request or mandate, may be legally supportable. If your child's therapist believes that disclosure of treatment information to you or others (e.g., attorney or court) would harm your child, your child's therapist will explain this to you and ask you to withdraw your request in order to preserve the therapy relationship and/or to avoid potential actions to preserve your child's treatment information, even if mandated by subpoena to disclose.

RELEASE OF PSYCHOLOGICAL TESTING DATA AND MATERIALS

If you request a copy of your child's testing data, a charge of \$25.00 for retrieval and verification fees is required along with completion of FPC's HIPAA-compliant authorization to release the records to a licensed psychologist of your choice. Please be aware that testing materials are copyrighted and trade-protected and are not required to be released to patients, parents, or attorneys under HIPAA. However, we are legally allowed to share test materials (e.g., test record forms, response sheets, computer-generated score reports) with another licensed psychologist. Once payment of the fee and our practice's release to the psychologist is signed by you, we will independently verify the credentials of the psychologist before sending the trade-protected documents. Due to the extra steps required in this type of request, it may take two weeks or longer to verify credentials and send test records.

TRAINING INSTITUTION

FPC, P.A. provides doctoral internship training accredited by the American Psychological Association. As such, some staff members are doctoral interns or postdoctoral residents. If your child's treatment provider is an intern or resident, your child's treatment information will be confidentially reviewed by the clinician and his or her clinical supervisor, a licensed psychologist on staff at our practice, on a frequent basis. The purpose of this review is to enrich your child's treatment services and provide additional training. Additionally, some services may be recorded to enrich intern supervision and the treatment of your child or adolescent. Recordings are confidentially reviewed by the intern and supervisor and securely deleted.

COURT OR LEGAL INVOLVEMENT

Unless the purpose of your child's services is clearly disclosed by you in writing on this intake form as related to Court, Legal, or Custody Issues (page 2), your child's therapist will serve as a treatment professional, not a forensic expert or court evaluator. Your child's therapist cannot ethically serve in both capacities. **Once treatment services begin (that is, at the time of the initial appointment), your child's treating therapist cannot later serve as a forensic expert for legal purposes.** Further, confidentiality in a treatment relationship (see above) requires a firm zone of privacy that will be established from the outset with your child. On the other hand, if you request services related to Court, Legal, or Custody issues on this intake form, your child will be informed from the outset (before starting the intake session) that the purpose of his or her services is related to legal issues and that anything he or she discusses may be shared with others in a written report and/or expert testimony.

Unless the purpose of seeking services is clearly disclosed in writing as related to Court/Legal/Custody Issues on this intake form (page 2), the parent or guardian agrees that he or she will refrain from requesting or mandating access to the child's confidential treatment records or conversations for legal purposes, including by subpoena or other legal actions. **If the parent or guardian chooses to request or legally mandate release of the child's confidential treatment information, despite his or her previous agreement to the treatment contract and its stricter confidentiality limits, the requesting parent or guardian agrees to tender a fee of \$1,200.00 in cash or check to Family Psychological Center, P.A. at the same time that that the request or subpoena is served to the therapist and/or Family Psychological Center, P.A.**

ASSIGNMENT OF HEALTHCARE BENEFITS

I authorize my insurance carrier to assign all health care benefits, if applicable, to Family Psychological Center, P.A. I also authorize release of my child's health care information necessary to process all insurance claims.

WAITING ROOM AND FAMILY MEMBERS

To maintain patient confidentiality and ensure adequate waiting room space for all patients, **family members (including siblings) or friends not directly involved in services that day should not enter the waiting room.** For child and adolescent patients, only caregivers should accompany the child or adolescent to our office. It is each parent's responsibility to obtain childcare for siblings in advance. If children and family members not involved in the appointment are in the waiting room, your child's appointment will be rescheduled and an \$80 fee must be paid for the missed appointment before another appointment will be scheduled. This compensates the provider for the time that he or she reserved for only you or your child. For safety purposes, unless you have direct permission from the therapist, child or adolescent patients are not allowed to sit in our reception area without parental supervision.

PARENT/GUARDIAN INVOLVEMENT

The **custodial parent and/or legal guardian must be present** for the child's initial appointment to give legal consent to provide services and furnish information about the child's symptoms, history, and other pertinent information. If the child has two custodial parents (as in shared custody after a divorce), **both parents must attend** the intake session **or** the parent who does not attend must provide written consent to treat the child. This form can be obtained at our office and must be signed at our office *at least 2 days* before the child's initial appointment.

PAYMENT POLICY

Co-payments are to be collected at the time of your child's appointments, just before sessions begin. **We accept cash and checks only (no credit cards or debit cards).** All mental health services are directly charged to the patient or responsible party. If your child's provider is contracted with your insurance carrier, we will accept the negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Some billable services may be required that are not reimbursed by insurance but are time consuming for your provider (e.g., writing letters, testing more than allowable hours, court testimony—if in a legal case). We do not bill insurance for court-related evaluations and therapy; services provided in a legal context must be paid in full before services are provided. If non-billable services are requested or required, you will be advised beforehand, if possible. Your payment is expected in full at the time of the service.

BILLING FOR PSYCHOLOGICAL TESTING

If psychological testing is conducted, your provider will spend time administering tests to your child or adolescent. After the testing appointment is completed, your provider then invests considerable additional time to score, interpret, and write a professional report of your youth's test results. Although the time needed to interpret test results varies based on the specific tests administered, our providers require approximately one hour of scoring and report writing time for every two hours of direct face-to-face test administration with your child/adolescent. You will be required to pay your estimated portion of the fees for each appointment just before the start of each testing session (based on the benefits information the insurance company provides to us). Billing adjustments will be made if scoring and interpretation take more or less time than this estimate. As a courtesy, our office will bill your child's insurance company/companies for testing services with your permission, if applicable. Most insurance companies now reimburse providers for scoring and report writing time. If your child's provider is a network provider for the insurance carrier(s), we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by the insurance company(ies) and billed accordingly.

CANCELLATION POLICY

We reserve appointment hours for only you and your child. **So, we require at least 24 hour notice if you need to cancel or reschedule your child's appointment.** This allows us time to contact another patient and schedule in the vacated appointment slot. We reserve the right to charge an **\$80.00 fee** for a "no show" appointment or an appointment canceled less than 24 hours in advance, which must be collected before your child's next appointment is scheduled. Insurance and Medicaid do not pay providers for missed appointments. The fee of \$80 makes up for the provider's lost work time and income for appointment hours that cannot be rescheduled because 24 hour notice was not provided. ***Cancellations must be made in person or by phone, not emailed. If the phone is not answered by our staff at the time you call to reschedule or cancel, you must leave a voicemail message on our office line (870-743-6225) to notify us.***

RECEIPT AND AGREEMENT TO NOTICE OF OFFICE POLICIES

I HAVE READ, UNDERSTAND, AND FULLY AGREE TO ABIDE BY THE ABOVE RELEASE OF HEALTHCARE INFORMATION, PAYMENT ARRANGEMENTS, WAITING ROOM POLICIES, CANCELLATION POLICY AND FEES, COURT OR LEGAL INVOLVEMENT, AND ALL OTHER OFFICE POLICIES FOR MY CHILD OR ADOLESCENT AS EXPLAINED IN THE "NOTICE OF OFFICE POLICIES FOR CHILD AND ADOLESCENT PATIENTS" ON PAGES 3 THROUGH 4 OF THIS INTAKE FORM.

FURTHER, BY SIGNING BELOW, I GIVE MY INFORMED WRITTEN CONSENT TO ALLOW PSYCHOLOGICAL TREATMENT SERVICES TO MY CHILD OR ADOLESCENT.

Signature of Responsible Party: _____ Date: _____

Printed Name of Responsible Party:

_____ First Middle Last

PATIENT NOTICE OF PRIVACY PRACTICES

The undersigned hereby acknowledges receiving a copy of the "Patient Notice of Privacy Practices" from Family Psychological Center, P.A. This is available from our office or at www.fpcharrison.com.

Child/Adolescent Patient's Name Date of Birth _____

Signature of Patient or Authorized Representative Date _____

CONSENT TO CALL

With permission, we remind patients by phone about appointments when possible. If patients are not available, we do not leave messages unless the patient or authorized representative authorizes us to do so. Initial the methods of contact you will permit.

- _____ I consent and authorize Family Psychological Center, P.A. to call my residence for appointment reminders.
- _____ I consent and authorize Family Psychological Center, P.A. to leave a message at my residence for appointment reminders.
- _____ I consent and authorize Family Psychological Center, P.A. to call my cell phone for appointment reminders.
- _____ I consent and authorize Family Psychological Center, P.A. to leave a message on my cell phone for appointment reminders.
- _____ I consent and authorize Family Psychological Center, P.A. to call my place of employment for appointment reminders.

I understand and allow Family Psychological Center, P.A. to contact me by means of the initialed methods above. I understand that phone contact may become known by anyone with access to my phone or caller ID systems.

Patient Name Date of Birth _____

Signature of Patient or Authorized Representative Date _____

Reminders:

- 1) **Present all active insurance card(s)**, if applicable, when you return this paperwork to our office. We will make copies.
- 2) For your paperwork to be complete, the **Developmental History Questionnaire** (on the following pages) should also be completed and received.
- 3) Before returning to us, please ensure that all signature are provided and all questions are answered to prevent delays.

We appreciate your interest in our professional services and look forward to working with you and your child!

OFFICE USE ONLY

Date Received _____

Received By _____

Incomplete Sections _____

Notes _____

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DEVELOPMENTAL HISTORY QUESTIONNAIRE
(For Ages 2-18)

Directions: Please *print* your answers neatly so we can read your responses. Although this questionnaire is lengthy, the information you provide will greatly enhance the thoroughness of your child or adolescent's evaluation and treatment.

IDENTIFYING INFORMATION

Person Completing this Form: _____ **Today's Date:** ____ - ____ - ____
First Middle Last

What Is Your Relationship to the Child/Adolescent? _____

Child/Adolescent's Name: _____ **Sex:** M F **DOB:** ____ - ____ - ____
First Middle Last

Your Address: _____

Your Cell Phone Number: _____ **Your Email Address:** _____

REASONS FOR EVALUATION:

Please list the reason(s) your child or adolescent is being referred to us:

1. _____

2. _____

3. _____

When did these problems begin?

What are your goals for seeing us?

Is this evaluation related to any legal issues, such as child custody, Medicaid waiver, or Social Security Disability?
 Yes No If yes, please describe: _____

What type of services are you seeking? (Check all that apply.)

- | | | |
|---|--|--|
| <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Diagnostic Clarification | <input type="checkbox"/> Assess for School/Learning Problems |
| <input type="checkbox"/> Individual Counseling/Therapy | <input type="checkbox"/> Family Counseling/Therapy | <input type="checkbox"/> Assess for Legal Charges |
| <input type="checkbox"/> Assess for Disability or Waiver Services | <input type="checkbox"/> FINS Adjudication | <input type="checkbox"/> Doctor/Primary Care Provider Referral |

FAMILY INFORMATION:

Mother/Guardian Name: _____ **Education:** _____

Occupation: _____ Full-time Part-time

Father/Guardian Name: _____ **Education:** _____

Occupation: _____ Full-time Part-time

Parents are:

- Married
- Unmarried, Living Together
- Never Married, Living Together
- Separated
- Divorced
- Mother Deceased
- Father Deceased

Child lives with: (Check all that Apply)

- Biological Mother
- Biological Father
- Step-parent
- Adoptive Parent (specify) _____
- Grandparent
- Legal Guardian (specify) _____
- Other (specify) _____
- Split custody (Lives in homes of both divorced parents)

SIBLING INFORMATION:

Name of sibling	Sex	Age	Same Father?	Same Mother?	List any health/behavior/ learning problems	Lives with child?
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N

How well does your child get along with his/her siblings?

- Very Well Good Average Fair Poor

Is English the child's primary speaking language? Yes No

If no, what is the child's primary language? _____ What is the child's secondary language? _____

CHILD CARE AND DISCIPLINE:

Who is primarily responsible for the child's care? Mother Father Both Other: _____

Who is mainly in charge of discipline in the home? Mother Father Both Other: _____

Please describe any misbehavior patterns in the home and classroom. _____

Please describe discipline techniques used with the child/adolescent and effectiveness. _____

FAMILY PSYCHIATRIC HISTORY: (Check all that apply.)

Condition/Disorder	Father	Mother	Brother	Sister	Grandparent	Aunt/Uncle
Alcohol/Drug Addiction						
Anxiety						
ADHD						
Autism Spectrum Disorder						
Bipolar Disorder						
Depression						
Epilepsy/Seizure Disorder						
Genetic Disorder/Condition						
Intellectual Disability/MR						
Jail Time/Incarceration						
Language Disorder						
Learning Disability						
Mental Health Hospitalization						
Motor or Vocal Tics/Tourette's						
Psychosis or Schizophrenia						
Special Education Services						
Speech Difficulties/Therapy						
Substance Abuse Arrests/DWI						
Suicidal Thoughts/Attempts						
Other: _____						
Other: _____						

PREGNANCY AND BIRTH HISTORY:

Parents' ages when child/adolescent was born: Mom was _____ years old Dad was _____ years old

Was this pregnancy full term? Yes No If not, how many weeks before or after the expected due date was the baby born? _____ weeks Before After due date

Pregnancy number: 1st, 2nd, 3rd, 4th, other _____ Totals: # of pregnancies _____ # of miscarriages _____

Was this a multiple birth? Yes No Don't Know; if yes: Twins Triplets Quadruplets

Were the babies identical? Yes No Don't Know

Please describe any problems that occurred during previous pregnancies (e.g., miscarriage, premature labor and delivery, etc.):

Mother's health during pregnancy:

- | | |
|---|--|
| <input type="checkbox"/> No health problems during pregnancy | <input type="checkbox"/> Health during pregnancy not known |
| <input type="checkbox"/> Poor weight gain | <input type="checkbox"/> Excessive weight gain (>30 pounds) |
| <input type="checkbox"/> Severe nausea (<input type="checkbox"/> with dehydration) | <input type="checkbox"/> Preeclampsia/Toxemia |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Infections (Flu, measles, CMV) |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rh (blood group) factor incompatibility |
| <input type="checkbox"/> Other (specify) _____ | |

List medications taken during this pregnancy: _____

Did the mother consume alcohol during this pregnancy? Yes No If yes, how many drinks per week? _____

Did the mother smoke during pregnancy? Yes No If yes, how many cigarettes per day (average)? _____

Did the mother consume illicit drugs during the pregnancy? Yes No If yes, which drugs and how much?

LABOR AND DELIVERY:

No problems during labor and delivery Not known Was prenatal care provided during pregnancy? Yes No

Was medication given to prolong pregnancy? Yes No If yes, at what week of pregnancy? _____

Was medication given to induce delivery? Yes No

Please note whether any problems occurred during labor or delivery (check all that apply):

EXCESSIVE BLEEDING

FORCEPS USED

Meconium staining

Umbilical cord around baby's neck

Fever or infection of mother

Breathing difficulties of child

Placenta previa or abruption

Placenta (water) broke more than 1 day before delivery

Other (specify): _____

Child was born: head first breech (feet first) vaginal Cesarean (Why? _____)

Birth weight _____ lbs _____ oz **Length** _____ in. (if known) **Head circumference** _____ in. (if known)

Apgar Scores (if known): _____ at 1 min _____ at 5 min

NEWBORN PERIOD:

Was the child healthy as a newborn? Yes No If not, please describe the problems and treatment: _____

Was the child born with any birth defects? Yes No If yes, explain: _____

Did the child require treatment in a newborn intensive care unit? Yes (for _____ days) No If yes, please describe. _____

Did the baby require any special care immediately after birth? No Yes If yes, please describe. _____

Check all that apply below.

Breathing problems (requiring oxygen ventilator (with a tube in windpipe)

Was cyanotic/turned blue

Placement in an incubator

Blood transfusions

Significant muscle weakness or paralysis

Poor muscle tone

Seizures

Feeding difficulties

Excessive sensitivity to noise/stimulation

Jaundice treated with lights

Infection

Surgery (describe): _____

DEVELOPMENTAL HISTORY:

Social Development

Have you noticed any past or current delays in the child's social development? Yes No

As an infant, did/was the child: (Describe to right of check mark.)

- Difficult to feed? Yes No _____
- Difficult to get to sleep? Yes No _____
- Enjoying cuddling? Yes No _____
- Easy to comfort? Yes No _____
- Cheerful? Yes No _____
- Sociable? Yes No _____
- Tend to be fussy/irritable? Yes No _____
- Make appropriate eye contact? Yes No _____
- Respond to his/her name? Yes No _____

During the first four years of life, were any special problems noted in the following areas? (If yes, please describe below.)

- Anger outbursts Yes No _____
- Separating from parents Yes No _____
- Excessive crying Yes No _____
- Playing with other children Yes No _____
- Overactivity, in constant motion Yes No _____
- Very stubborn, challenging Yes No _____

Speech and Language Development

Did you notice any delays in the child's language development? Yes No

If yes, please specify: _____

Did the following milestones develop on time? Please specify age (year/month).

- Show interest in sound (by 3 months) Yes No _____
- Babbling (by 4 to 6 months) Yes No _____
- Understanding words (by 6-11 months) Yes No _____
- Speaking first words (by 12 months) Yes No _____
- Speaking in short phrases (by 24 months) Yes No _____

Motor Development

Did you notice any delays in the child's motor development? Yes No

If yes, please specify: _____

Did the following milestones develop on time? *Please specify age (year/month).*

- Turn over (by 6 months) Yes No _____
- Sit alone (by 9-12 months) Yes No _____
- Crawl (by 9-12 months) Yes No _____
- Stand alone (by 9-12 months) Yes No _____
- Walk without support (by 12-18 months) Yes No _____
- Walk upstairs (by 36 months) Yes No _____
- Walk downstairs (by 48 months) Yes No _____
- Running Yes No _____

Which hand does your child use for writing or drawing? Right Left Both

Does your child grip writing instruments correctly when writing and drawing? Yes No _____

Daily Living

Has your child completed toilet training? Yes No

If not toilet trained, does he/she still have daytime bowel accidents? nighttime bowel accidents?

If not toilet trained, does he/she still have daytime bladder accidents? nighttime bladder accidents?

If toilet trained, how old was your child when he/she stopped having toileting accidents?

During the Day: _____ During the Night: _____

Did bedwetting resume after toilet training was completed? Yes No If yes, until what age? _____

Did bed-soiling resume after toilet training was completed? Yes No If yes, until what age? _____

Does your child have difficulty with overreacting or underreacting to sensory information? Yes No

If yes, please describe below:

Tolerating Food Textures Yes No _____

Gagging or Vomiting Yes No _____

Tolerating Clothing Yes No _____

Tolerating Touch from Others Yes No _____

Does Not Notice Pain Yes No _____

Other _____

Significant LOSS of an acquired skill or skills (not just a delay)? For example, a child who was engaging in pretend play with other children for at least 4 to 6 months and then stopped and began just spinning, dropping, or throwing objects in his/her free time or speaking in full sentences for many months and then just stopped speaking altogether or began using only single words occasionally)

Social functioning Age of loss: _____ months; Explain: _____

Speech/language Age of loss: _____ months; Explain: _____

Problem solving Age of loss: _____ months; Explain: _____

Motor coordination Age of loss: _____ months; Explain: _____

Bladder/bowel control Age of loss: _____ months; Explain: _____

MEDICAL HISTORY:

Who is your child's primary care doctor? _____ Phone Number: _____

Is your child followed by other healthcare professionals or specialists? Yes No If yes, name(s) and specialty(ies): _____

No serious illnesses or injuries in the **past** No serious illnesses or injuries **now**

Date	Age	Diagnosis/Illness	Past	Now	Date	Age	Diagnosis/Illness	Past	Now
		SERIOUS INJURIES	<input type="checkbox"/>	<input type="checkbox"/>			LUNG/BREATHING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
		Serious head injury	<input type="checkbox"/>	<input type="checkbox"/>			Asthma	<input type="checkbox"/>	<input type="checkbox"/>
		Other serious injury	<input type="checkbox"/>	<input type="checkbox"/>			Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
		Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>			Apnea or irregular breathing	<input type="checkbox"/>	<input type="checkbox"/>
		SLEEP PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>			Other:	<input type="checkbox"/>	<input type="checkbox"/>
		NEUROLOGICAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>			STOMACH/BOWEL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
		Birth abnormality	<input type="checkbox"/>	<input type="checkbox"/>			Swallowing problems	<input type="checkbox"/>	<input type="checkbox"/>
		Seizures (type: _____)	<input type="checkbox"/>	<input type="checkbox"/>			Gastroesophageal reflux	<input type="checkbox"/>	<input type="checkbox"/>
		Other:	<input type="checkbox"/>	<input type="checkbox"/>			Chronic abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
		VISION PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>			Chronic diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
		Vision problems at birth	<input type="checkbox"/>	<input type="checkbox"/>			Chronic constipation	<input type="checkbox"/>	<input type="checkbox"/>
		Requires glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>			Other:	<input type="checkbox"/>	<input type="checkbox"/>
		Other: _____	<input type="checkbox"/>	<input type="checkbox"/>			KIDNEY/BLADDER PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
		HEARING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>			Abnormalities at birth	<input type="checkbox"/>	<input type="checkbox"/>
		Hearing problems at birth	<input type="checkbox"/>	<input type="checkbox"/>			Kidney/bladder infections	<input type="checkbox"/>	<input type="checkbox"/>
		Deafness	<input type="checkbox"/>	<input type="checkbox"/>			Other:	<input type="checkbox"/>	<input type="checkbox"/>
		Chronic/repeated ear infections	<input type="checkbox"/>	<input type="checkbox"/>			MUSCLE/BONE/JOINT) PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
		Ear tubes	<input type="checkbox"/>	<input type="checkbox"/>			Abnormalities at birth	<input type="checkbox"/>	<input type="checkbox"/>
		Other: _____	<input type="checkbox"/>	<input type="checkbox"/>			Scoliosis or spinal curvature	<input type="checkbox"/>	<input type="checkbox"/>
		DENTAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>			CIRCULATORY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
		Abnormally/missing teeth	<input type="checkbox"/>	<input type="checkbox"/>			Anemia	<input type="checkbox"/>	<input type="checkbox"/>
		Extractions/cavities	<input type="checkbox"/>	<input type="checkbox"/>			Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>

		Dental braces	<input type="checkbox"/>	<input type="checkbox"/>			Chronic low platelet count	<input type="checkbox"/>	<input type="checkbox"/>
		Other: _____	<input type="checkbox"/>	<input type="checkbox"/>			Bleeding /bruising problem	<input type="checkbox"/>	<input type="checkbox"/>
		SKIN PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>			Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
		Eczema	<input type="checkbox"/>	<input type="checkbox"/>			HORMONE PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
		Ash leaf patches	<input type="checkbox"/>	<input type="checkbox"/>			Sugar diabetes	<input type="checkbox"/>	<input type="checkbox"/>
		Other: _____	<input type="checkbox"/>	<input type="checkbox"/>			Early puberty	<input type="checkbox"/>	<input type="checkbox"/>
		GROWTH PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>			Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
		Failure to gain weight	<input type="checkbox"/>	<input type="checkbox"/>			MENTAL HEALTH PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
		Obesity	<input type="checkbox"/>	<input type="checkbox"/>			ADHD	<input type="checkbox"/>	<input type="checkbox"/>
		Short stature	<input type="checkbox"/>	<input type="checkbox"/>			Oppositional defiant disorder	<input type="checkbox"/>	<input type="checkbox"/>
		Tall stature	<input type="checkbox"/>	<input type="checkbox"/>			Anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>
		Other: _____	<input type="checkbox"/>	<input type="checkbox"/>			Obsessive-compulsive disorder	<input type="checkbox"/>	<input type="checkbox"/>
		HEART PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>			Depression	<input type="checkbox"/>	<input type="checkbox"/>
		Heart abnormalities at birth	<input type="checkbox"/>	<input type="checkbox"/>			Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>
		Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>			Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
		Heart rhythm abnormalities	<input type="checkbox"/>	<input type="checkbox"/>			Tic disorder (e.g., Tourette's)	<input type="checkbox"/>	<input type="checkbox"/>
		High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>			Intellectual disability	<input type="checkbox"/>	<input type="checkbox"/>
		Other: _____	<input type="checkbox"/>	<input type="checkbox"/>			Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>

I have confirmed with my child's Primary Care Doctor that his/her immunizations are up to date. Yes No
 If no, explain: _____

Specialized neurological or genetic tests:

Has genetic or neurological testing been performed? Yes No

Check If performed	Date (MM/YY)	Test/Procedure	Normal Result	Abnormal Result (Describe)	Unknown Result
<input type="checkbox"/>		EEG (Brain wave testing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		CT Scan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		MRI Scan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		PET/SPECT scan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		Other Scan (specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		Chromosomal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		DNA Testing for Fragile X Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		Other genetic test: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List all hospitalizations and surgeries for the child, include overnight stays (medical or behavioral).

No past hospitalizations or surgery

Reason for hospitalization OR type of surgery	Age	Length of stay

Allergies (to medications, foods, environmental antigens, etc.)

No past or current allergies

Source (medication, food, pollen, etc.)	Describe reaction (breathing issues, rash, etc.)

Current Medications

No medications taken now.

Medication Name	Dosage	How Long on Medication?	Condition Treated	Improvement?	
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No

Name of healthcare professional who prescribes above medications: _____

RESOURCES: Please indicate resources/services received, both currently and in past.

No resources/services are being received now

Type of Services	History of Service			Name of Agency/Provider	Dates Treated	Improvement?	
	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Current			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Early Intervention/ Developmental Services	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Current			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Speech/Language Therapy	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Current			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Occupational Therapy	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Current			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical Therapy	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Current			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mental Health Counseling	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Current			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Case Management	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Current			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other? _____	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Current			<input type="checkbox"/> Yes	<input type="checkbox"/> No

EDUCATIONAL HISTORY:

Current School: _____ Grade in School: _____

Name of Current Teacher(s): _____

Has your child ever repeated a grade? Yes No If yes, which grade(s)? _____ Why held back? _____

What is(are) your child's most difficult subject(s)? _____

What is(are) your child's best school subject(s)? _____

Please describe your child's attitude about school. _____

Has your child ever been suspended? Yes No If yes, how many times, which grades, and why?

Has your child ever been expelled? Yes No If yes, how many times, which grades, and why?

Is your child currently on a formal education plan in school? Yes No

If yes, please check: IEP 504 Plan

What best describes the child's current educational program?

- Full time in a regular class
- Time split between regular and special education classes
- Special education class
- Aide/Paraprofessional or extra help
- Specialized school
- Home schooled

Please indicate the school, specialized services, and performance for each year of school.

Grade in School	Name of School	Any Specialized Services? (SPED, SLT, OT, PT, etc.)	Average Academic Grades (As, Cs, etc.)	Behavioral Performance
Age 3-5 (PreK)				
Kindergarten				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

LEGAL HISTORY:

Has child protective services (DHS, DCFS) ever investigated allegations of abuse or neglect of your child? Yes No

If yes, when were allegations investigated? _____ In what state(s)? _____

Who was the alleged offender(s)? _____

What was the outcome of the investigation? _____

Has your child ever been adjudicated in a FINS (Family In Need of Services) case? Yes No If yes, please describe below:

Has your child/adolescent ever been arrested or convicted for committing crimes? Yes No If yes, please describe below.

SOCIAL AND BEHAVIORAL FUNCTIONING:

Peer Relationships (Please indicate how the child relates to peers:)

- Has problems relating to other children
- Has difficulty making friends
- Fights frequently with peers
- Prefers playing with younger children
- Prefers playing with older children
- Prefers to play alone
- Has a best friend
- Seems uninterested in friendships/peers
- Friends tend to be negative influences
- Positive relationships with peers

What role does your child or adolescent tend to take in peer groups? Leader Follower Some of Each

How many friends does the child have? _____ Does he/she have problems keeping friends? Yes No

RECREATIONAL INTERESTS:

What does your child enjoy?

- Sports _____
- Hobbies _____
- Other _____

What are your child's personal strengths?

What do you enjoy most about your child?

What are your hopes for your child?

RECENT FAMILY STRESSORS:

Please describe any recent family, school, or social stressors that have occurred in your child's life.

OTHER COMMENTS:

Please let us know anything else about your child/adolescent that would help us understand him/her better.

REMINDERS

- 1. Please double check to ensure all questions are answered on this *Developmental History Questionnaire*.**
- 2. Return this questionnaire as well as the *Child/Adolescent Intake Form* to our office.**
- 3. Please take all active insurance cards to our office with these forms.**
- 4. After we receive all this important information, your child or adolescent will be scheduled for an initial intake appointment as soon as an intake opening is available.**