FAMILY PSYCHOLOGICAL CENTER, P.A.
623 NORTH WALNUT ST · HARRISON, ARKANSAS 72601
PHONE: (870) 743-6225 · FAX: (870) 743-6006
fpcpa.net

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, DO NOT COMPLETE THIS FORM. INSTEAD, FORWARD THIS FORM TO THE 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 ☐No Custody ☐Shared Custody ☐ Sole Custody ☐ Visitation ☐Supervised Visitation

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, 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 *(circle one)*		
Negative View of Future/Hopelessness		
Weight Loss/Gain (circle one)		
Difficulty Making Decisions		
Appetite Increase/Decrease *(circle one)*		
Excessive Joy or Grand Feelings		
Risky Behaviors (splurges, drive fast, stealing) *(circle)*		
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) *(circle)*		
Difficulty Relaxing		
Panic or Anxiety Attacks		
Nightmares		
Memories of Traumatic Event(s)		
Bedwetting/Refusal to Sleep Alone *(circle all that apply)*		
Fear of Objects/Situations/Crowds *(circle all that apply)*		
Constant and Disturbing Worries		
Rituals-Compulsions (counting, ordering, echoing) *(circle)*		
Developmental Delay (speech, motor, social skills) *(circle)*		
Math/Reading/Writing Problems *(circle all that apply)*		
Failing Grades/Skipping School *(circle all that apply)*		

Symptom	0-3	How Long?
Alcohol Misuse		
Drug Misuse		
Oppositional and Defiant Attitudes		
Decreased Academic Performance		
Conflict (parents, siblings, teachers) *(circle)*		
Lack of Friends/Negative Friends *(circle)*		
Sexual Acting Out		
Hallucinations (hearing voices, seeing things) *(circle)*		
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 *(circle those that apply)*		
Twitches/Tics *(circle those that apply)*		
Worry about Gaining Weight/Restricting Calories		
Inducing Vomiting/Misuse of Laxatives *(circle)*		
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.

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 $1,500.00 in cash or cashier's 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. **I also agree to advise FPC as soon as any changes to my coverage occur and understand that failure to do so may result in rejected claims and/or increased fees that I will be responsible for paying.**

WAITING ROOM AND FAMILY MEMBERS
To maintain patient confidentiality, minimize risk to staff and patients, and ensure adequate waiting room space for all patients, **only the child and his/her parents or caregivers are allowed in the office. Other family members (including siblings) or friends should not enter the waiting room.** 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 a $100 no show/late cancel fee must be paid for each scheduled hour of 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. **Also, at least one parent or caregiver must remain inside our office throughout the appointment.**

PARENT/GUARDIAN INVOLVEMENT
At least one custodial parent and/or legal guardian must be present for the child's intake 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 are required attend** the intake session **OR** the parent who does not attend must provide written consent to treat the child before the intake appointment can be scheduled. This form can be obtained at our office and must be signed at our office before the child's initial appointment is scheduled. If a custodial parent/caregiver is unable to sign a consent to treat form in person, he/she must provide photocopy of state ID with the signed form to confirm his/her identity.

PAYMENT POLICY
Your payment must be collected at the time of your child's appointments, before sessions begin. We accept cash and checks only **(not credit cards or debit cards)**. Before your child's intake appointment, we will provide you with an estimate of your charges for services. If your child has insurance and our provider is in-network, we will contact the insurance company as a courtesy to check eligibility and benefits. If our provider is contracted with your child's insurance carrier(s) and the policy covers the services provided, we will accept their negotiated rate for the charges billed. However, some insurance companies do not provide coverage for required billable services that are time consuming for our provider (e.g., writing letters if requested, psychological testing, testing more than allowable hours in the same day). You will be required to pay in full for all services not covered by your child's insurance policy at the time of each appointment. If non-billable services are requested or required, you will be advised beforehand, *if possible*. 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.

BILLING FOR PSYCHOLOGICAL TESTING
If psychological testing is required, your provider will spend time administering tests to your child. After you leave the office, your provider will invest additional time to score, interpret, and write up test results in a professional report. Although the time needed to interpret testing results varies based on the specific tests and number of tests administered, our providers require approximately one to two hours of scoring and report writing time for every two hours of direct face-to-face test administration with your child. You will be required to pay your estimated portion of the fees for each appointment just before the start of each appointment (if using insurance, based on benefits information your insurance company provides to us). Billing adjustments will be made if actual benefits differ from information provided by your child's insurance company and/or if scoring and interpretation take more or less time than this estimate. If our provider is in network for your child's insurance carrier(s) and coverage is provided for testing services that your child receives, we will accept the negotiated rate. Although most insurance companies now reimburse providers for testing as well as scoring and report writing time, you will be required to pay for all services not covered by your insurance at the time of service.

ATTENDANCE AND CANCELLATION POLICY
Our office requires that if you need to cancel or reschedule appointments, we must receive notice from you **at least one business day, that is 24 hours (weekend days do not count toward notice),** before the appointment. This allows us time to contact another client and schedule them in your child's vacated appointment slot. We reserve the right to charge a no show/late cancel fee of **$100.00 per scheduled hour**. For instance, if 3 hours are reserved for your child's appointment, the no show/late cancel fee would be $300. This fee must be received before your child's next appointment is scheduled. Cancellations must be made in person or by phone, *not email*. Voicemails must be left on our office line (870-743-6225) if the phone is not answered at the time you call to reschedule or cancel an appointment. Prompt arrival is also essential. If you arrive **more than 10 minutes late**, your appointment may have to be rescheduled. In that case, a no show/late cancel fee would also apply.

RECEIPT AND AGREEMENT TO NOTICE OF OFFICE POLICIES

I HAVE READ, UNDERSTAND, AND FULLY AGREE TO ABIDE BY THE ABOVE RELEASE OF HEALTHCARE INFORMATION, ASSIGNMENT OF HEALTHCARE BENEFITS, PAYMENT POLICIES, WAITING ROOM POLICIES, ATTENDANCE AND 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 WRITEN CONSENT TO ALLOW PSYCHOLOGICAL TREATMENT SERVICES TO MY CHILD OR ADOLESCENT AND AFFIRM I AM AUTHORIZED BY LAW TO MAKE MEDICAL DECISIONS FOR 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 **fpcpa.net**

_____ _____
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, at the same time that 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 signatures 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/adolescent!

OFFICE USE ONLY

Date Received _____

Received By _____

Incomplete Sections _____

Notes_____

THIS PAGE IS INTENTIONALLY BLANK.

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.)

☐ Psychological Testing	☐ Diagnostic Clarification	☐ Assess for School/Learning Problems
☐ Individual Counseling/Therapy	☐ Family Counseling/Therapy	☐ Assess for Legal Charges
☐ Assess for Disability or Waiver Services	☐ FINS Adjudication	☐ 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?
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐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:

☐ No health problems during pregnancy
☐ Poor weight gain
☐ Severe nausea (☐ with dehydration)
☐ Seizures
☐ Health during pregnancy not known
☐ Excessive weight gain (>30 pounds)
☐ Preeclampsia/Toxemia
☐ Infections (Flu, measles, CMV)

☐ High blood pressure
☐ Rh (blood group) factor incompatibility
☐ 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 9-12months)	☐ 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 <u>LOSS</u> 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	☐	☐			**LUNG/BREATHING PROBLEMS**	☐	☐
		Serious head injury	☐	☐			Asthma	☐	☐
		Other serious injury	☐	☐			Pneumonia	☐	☐
		Loss of consciousness	☐	☐			Apnea or irregular breathing	☐	☐
		SLEEP PROBLEMS	☐	☐			Other:	☐	☐
		NEUROLOGICAL PROBLEMS	☐	☐			**STOMACH/BOWEL PROBLEMS**	☐	☐
		Birth abnormality	☐	☐			Swallowing problems	☐	☐
		Seizures (type:_____)	☐	☐			Gastroesophageal reflux	☐	☐
		Other:	☐	☐			Chronic abdominal pain	☐	☐
		VISION PROBLEMS	☐	☐			Chronic diarrhea	☐	☐
		Vision problems at birth	☐	☐			Chronic constipation	☐	☐
		Requires glasses/contacts	☐	☐			Other:	☐	☐
		Other: _____	☐	☐			**KIDNEY/BLADDER PROBLEMS**	☐	☐
		HEARING PROBLEMS	☐	☐			Abnormalities at birth	☐	☐
		Hearing problems at birth	☐	☐			Kidney/bladder infections	☐	☐
		Deafness	☐	☐			Other:	☐	☐
		Chronic/repeated ear infections	☐	☐			**MUSCLE/BONE/JOINT) PROBLEMS**	☐	☐
		Ear tubes	☐	☐			Abnormalities at birth	☐	☐
		Other: _____	☐	☐			Scoliosis or spinal curvature	☐	☐
		DENTAL PROBLEMS	☐	☐			**CIRCULATORY PROBLEMS**	☐	☐
		Abnormally/missing teeth	☐	☐			Anemia	☐	☐
		Extractions/cavities	☐	☐			Sickle cell disease	☐	☐

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

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
☐		EEG (Brain wave testing)	☐	☐	☐
☐		CT Scan	☐	☐	☐
☐		MRI Scan	☐	☐	☐
☐		PET/SPECT scan	☐	☐	☐
☐		Other Scan (specify:_____)	☐	☐	☐
☐		Chromosomal	☐	☐	☐
☐		DNA Testing for Fragile X Syndrome	☐	☐	☐
☐		Other genetic test:_____	☐	☐	☐

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?	
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ 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?	
Early Intervention/ Developmental Services	☐ Never	☐ Past	☐ Current			☐ Yes	☐ No
Speech/Language Therapy	☐ Never	☐ Past	☐ Current			☐ Yes	☐ No
Occupational Therapy	☐ Never	☐ Past	☐ Current			☐ Yes	☐ No
Physical Therapy	☐ Never	☐ Past	☐ Current			☐ Yes	☐ No
Mental Health Counseling	☐ Never	☐ Past	☐ Current			☐ Yes	☐ No
Case Management	☐ Never	☐ Past	☐ Current			☐ Yes	☐ No
Other?_____	☐ Never	☐ Past	☐ Current			☐ Yes	☐ 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 and a referral from your child's health care provider (if required), your child or adolescent will be scheduled for an initial intake appointment as soon as an intake opening is available.**