Psychological Assessment Intake

Client Name:	Date:
Date of Birth:	Purpose of Evaluation:
Age:	

FAMILY STRUCTURE

Mother's Name:	Live in the home?
Father's Name:	Live in the home?
Siblings:	Live in the home?
Other occupants:	
Recent move or structure change?	
Relationship with Family Members:	
Other Information:	

GROWTH AND DEVELOPMENT

Place of birth:	Gestation:
Birth weight/length:	Vaginal/C-Section/Other
Complications?	
Physical Development:	
Language Development:	
Treatment for Developmental Issues?	

Psychological Assessment Intake

EDUCATION

School:	Grade:
Teacher's Name:	Have an IEP?
Accommodations:	
Areas of Strength:	
Areas of Improvement:	
Interactions with Peers:	
Behavior:	

MEDICAL HISTORY

Current Primary Care Physician:
Current Psychiatrist:
Medications/Dosage:
Any previous medications?
Medical Concerns:

Psychological Assessment Intake

BEHAVIOR

Current Bedtime: Hours of Sleep:	Sleep Disturbances?
Current Eating Habits:	
Sensory Issues (Past):	
Sensory Issues (Current):	
Repetitive Behavior (Past):	
Repetitive Behavior (Current):	
Behavioral Issues:	
Leisure Activities:	

OTHER INFORMATION
