CHILD INTAKE FORM

General Information

Name: _____ **Date of Birth:** _____

Address: _____ **Zip Code:** _____

Phone Number: _____ **City:** _____

Does Child live with both parents? _____

Mothers Name: _____ **Age:** _____

Mothers Occupation: _____ **Work Phone:** _____

Email Address:_____

Fathers Name: _____ **Age:** _____

Fathers Occupation: _____ **Work Phone:** _____

Email Address: _____

Pediatrician: _____

Telephone Number: _____

Does your child have any siblings? _____

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If yes, please list them including name and ages.

Name: Sister/Brother: Age/:

1._____

2._____

3._____

4._____

Concerns:
Please describe your primary concern(s):

Health and Medical Information

Are you under the care of other medical specialists**?** _____

If yes, please describe:

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Please describe your child's overall physical health?

Please provide any pertinent medical history including any testing that has been done:

Date	Type	Diagnosis	Recommendations

Head Injury

Has your child ever had a head injury such as a concussion? _____
If yes, please describe (year, treatment):

Seizures

Have you ever had a seizure? _____
If yes, please describe (frequency, medication):

Medications

Please list all past and current medications and dosages:

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General Health

Has any of your immediate family member's experienced personal, social or learning problems? If yes, please describe?

Has your child ever suffered from a serious or debilitating illness? _____
If yes, please check from any of the following:

Respiratory Problems_____
Meningitis_____
Throat Problems_____
Skin Problem_____
Stomach Problems_____
Seizures_____
Bedwetting_____
High Fever_____
Ear Infections_____
Asthma_____
Allergies_____
Epilepsy_____
Self-Mutilation_____

Prenatal and Birth History:

Please describe mother's general condition during pregnancy? (Illness, accidents, medications):

Length of pregnancy: _____

General Condition: _____ Birth Weight: _____

Type of delivery: Head First Feet First Breech
Cesarean
Did mother take any medication during the pregnancy? _____ If yes please describe:

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Were there any unusual conditions that may have affected the pregnancy or birth?
If yes, please describe:

Were there any complications with previous pregnancies?
Please describe:

Describe any separations between mother and infant during the first days of life?

In the first two years of the child's life what type of baby was she/he? (feeding, sleeping activity level, etc.)

Temperament

Choose up to three words that best describe your child's temperament (personality) during infancy and early childhood.

Medical History

Please circle any of the following that apply to your child:

Allergies Frequent Colds

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Dizziness	Encephalitis
High Fever	Measles
Pneumonia	Tinnitus
Asthma	Convulsions
Draining Ear	Influenza
German Measles	Meningitis
Seizures	Tonsillitis
Chicken Pox	Croup
Ear Infections	Head Aches
Mastoiditis	Mumps
Sinusitis	Other

If you checked any of the above conditions, please explained:

Developmental History

Provide the approximate age at which the child began to do the following activities:

Crawl: _____ Walk: _____

Use Toilet: _____ Sit: _____

Feed Self: _____ Babbled: _____

Dress Self: _____ Reading: _____

Stand: _____ Writing: _____

Use single words (mama, dada, no): _____

Combine Words (my toy, mama car, etc.): _____

Use simple Sentences (where's mama): _____

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Name simple objects (cat, dog, car, toy): _____

Engage in conversation: _____

Auditory Development

Describe the child's response to sound (responds to all sound, responds to loud sound ONLY, inconsistently responds to sounds...etc.):

Has your child had auditory testing perform? _____
If yes, please indicate the date of testing and describe the test results:

Did/does your child have frequent ear infections? _____
If yes, please describe frequency, dates, and any treatments:

Does your child have hearing loss? _____
If yes, please describe:

SensoryMotor Function

Does your child have fine motor difficulties? _____
If yes, please describe:

Does your child have gross motor difficulties? _____
If yes, please describe:

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Does your child wet the bed? _____
If yes, please describe:

Sensitivities to touch or bothered by tags in shirts or wearing socks? ____
If yes, please describe:

Does your child participate in sports? ____
If yes, please describe:

Hand Preference

Please indicate L, R or A (ambidextrous) for the following task:/

General: _____ Throwing: _____

Writing: _____ Eating: _____

Brushing Teeth: _____ Brushing Hair:_____

Visual Development

Has your child had their vision tested? ____
If yes, please describe (vision therapist, type of therapy, duration):

Does your child wear glasses? _____

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Educational History

Current School: _____ Grade: _____
Does your child have an IEP?
If yes, what are his/ her qualifying diagnosis?

How is the child doing academically (preacademically if in preschool)?

Do you believe that your child has learning problems? ____
If yes, please describe?

Does the child receive special services such as therapies or other interventions? ____
If yes, please describe?

Has your child ever repeated a grade? ____
If yes, please explain:

How does the child interact with others at school? (shy, outgoing, aggressive):

List any agencies, psychologists, speech pathologist, tutors, educational therapist and others who have evaluated and/or provide treatment for your child.

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Comment on any significant academic difficulties that your child has experienced in school?

Comment on any significant academic successes or activities that your child seems most interested.

Provide any additional information that might be helpful in evaluating your child.

General Behavior

Please use the following scale to describe your child's overall behavior: Often, Sometimes, Rarely, Never:

Distractible: _____ Cooperative: _____

Organized: _____ Hyperactive: _____

Disorganized: _____ Hypoactive: _____

Tics: _____ Phobias: _____

Impulsive: _____ Inflexible: _____

Overreacts: _____ Complaint: _____

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Aggressive: _____ Low Frustration: _____

Short Attention Span: _____ Few/no friends: _____

High pain tolerance: _____ Low pain tolerance: _____

Socially immature: _____ Avoidance behaviors: _____

Sound sensitive: _____ Touch sensitive: _____

Odor sensitive: _____

Please respond to the following questions about your child's general behavior:

How does he/she typically respond to distractions?

How would you rate his/her response to difficult tasks?

How would you rate his/her level of organization?

Rate his/her follow through with homework?

How would you rate his/her listening skills?

How would you rate his/her attention?

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What is his/her attitude towards school?

Please describe his/her typical mood.

How well does she/he mix with peers?

Person completing form: _____ Relationship to Child: _____

Signed: _____ Date: _____

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