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Child Intake Form

DATE OF INTAKE: ____________

NAME: ____ **SEX:** ____________

DATE OF BIRTH: ________________ **GRADE:** _____________________________

SCHOOL: ____

HOME ADDRESS: ____

____

HOME PHONE NUMBER: ____

NAME OF INFORMANT(S):____

RELATIONSHIP TO CHILD:____

CELLULAR PHONE: _________________ **WORK PHONE:** ___________________

EMAIL ADDRESS: ____

BETTER WAY TO REACH YOU? ____

I. REASON FOR REFERRAL:

Who referred you to us?____

What do you perceive the problem to be? ________________________________
____
____
____

What would you like us to help you determine:______________________________
____
____
____

Why now?____
____

II. BACKGROUND INFORMATION

A. General background history

Name of Mother: ____

Education: ____

Profession: ____

Name of Father: ____

Education: ____

Profession: ____

List family members (siblings, other(s) living with child):

Relationship to child	Age	Gender	Lives at home?

B. Other pertinent background history

Parents' marital status? ____

If parents are not married, then:

Do you have a significant other? ______

Does s/he live with the family? ______

How do(es) the child(ren) get along with him/her? ______________________

____

____

If parent divorced or widowed:

When (how old was the child)? ____

Who has custody of the child? ____

Relationship with non-custodial parent: (How often does your child see him/her?) _____

____

Languages spoken other than English:______________________________________

What do you consider your (your child's) main language? ________________________

C. Developmental History:

Pregnancy with child: ____

____

Delivery and perinatal complications (at term, induced, C-section?)**:**

____

____

How was your child as a baby?____

____

Developmental Milestones: (comment on any problems)

1. Motor ____-____________
2. Language ____
3. Toilet trained (At what age? Accidents after toilet trained?) ____________________

____

D. Medical History:

1. Hospitalizations ?____

____

2. Chronic illnesses (asthma, diabetes, allergies, etc.)? ___________________________

____

3. Allergies ____
4. Ear infections (When? Frequency?): _______________________________________

   ____

5. Other illnesses: ____

   ____

6. Accidents: ____

   When? ____

   How did it happen? ____

   ____

   Loss of consciousness? _____________ For how long?________________________

History of past and present medications (do not include regular antibiotics for colds, etc.)

Medicine	Indication	Dosage	Duration of Treatment	Side Effects

E. School Information

Previous schools? ____

____

____

Why did your child change school? ____

____

When did school problems start? ____

Who first noticed problems?____

What kind of problems is your child having in school? ______________________________

____

What areas are the most difficult for him/her?______________________________

____

Did your child have a difficult time learning to read?______________________________

What are his grades? ____

Special placement in school? ____

Has your child has been evaluated in the past? ______________________________

Reasons for evaluation: ____

____

Has your child received tutoring in the past? For what? For how long?: ____________

____

____

Did it help or is it helping? ____

____

F. Social Life:

1. Does your child have many friends?____
2. Does s/he fight a lot with them? ____
3. What kind of activities does your child do with her/his friends?__________________

____

4. How does s/he get along with other children at school ?________________________

____

6. What does your child do for fun? (activities, hobbies, sports, etc.)

____

____

____

Additional information that could help us understand your child better:

____

____

____

____

Do you have any questions for us?____

____

____

____

____