Child Intake Form

Child's Name:_____ Today's Date:_____

Date of Birth:_____ Gender: _____

Parents/Guardians Name:_____
Marital Status:_____

Address:_____

Home Phone:_____

Work Phone:_____

School Child Attends:_____

Current Grade:_____

Referred by whom:_____

Who lives in the child's home, ages, and relation to child:_____
_____
_____

Reason for Referral: Please provide a brief description of current concerns:
_____
_____
_____
_____
_____
_____

How long has this been a concern: _____

Is this child currently under the care of a pediatrician or primary care doctor (PCP) for the treatment of a chronic medical illness, if so please explain
_____
_____
_____

This form was completed by:_____

If not parent, relation to the child:_____

Pregnancy Information:

Duration of pregnancy:_____, Single or Multiple Birth (circle one)

Circle all that apply to mother during pregnancy:

High Blood Pressure Eclampsia Pre term labor Bed rest Hospitalization

Labor Complications: Yes or No Duration of Labor: _____

Birth Weight: _____, Length_____

Labor: Spontaneous or Induced Delivery: Vaginal or Cesarean

Complications for infant (Circle all the apply): cord around neck

lack of oxygen breathing concerns hemorrhage other

Length of hospital stay: _____ In the NICU: _____

Infant History:

Infant/Toddler's Temperament (circle all that apply): laid back colicky

feeding concerns (breast feeding or formula) never liked to be held

Wanted to be held constantly demanding difficulty sleeping head banging

Constantly on the move climber angry

Developmental Milestone Attainment: Walked at _____ months; babbled at _____months, put two word sentences together at _____months; potty trained at _____months

Any speech or hearing concerns identified (please explain):

_____

_____

Developmental History:

Behavior	**Age**	**Behavior**	**Age**
Walk Alone	_____	Stayed Dry at Night	_____
Spoke first words	_____	Fed Self	_____
Put several words together	_____	Rode tricycle	_____
Totally Toilet Trained	_____		

Social History (please circle all that apply):

Difficulty making eye contact shy apprehensive

Gets along with peers difficulty making friends difficulty keeping friends

Academics (circle all that apply):

Trouble learning letters and sounds difficulty identifying numbers difficulty
Learning to read takes inordinate amount of time to complete homework
Difficulty remaining on task difficulty starting homework
Difficulty completing assignments unorganized
Often looses school papers procrastinator

Emotional Concerns (circle all that apply): shy depressed low energy
Apprehensive anxious withdrawn hyperactive

Family Psychiatric History (please circle all that apply):

Depression anxiety drug/alcohol abuse addictions bipolar

Schizophrenia Attention Deficit Hyperactivity Disorder

Learning disability autism Asperger

REASON FOR REFERRAL :

What specific services are you seeking?_____

Describe your child's current difficulties:_____

_____

_____

Have you received a previous evaluation or treatment for current difficulties?_____ If yes, please describe, briefly:_____

_____

_____

Please note all psychological difficulties that are present in parents and parents family of origin. Many psychological illnesses have a strong genetic componenet.

_____

_____

_____

Pediatrician's Name: _____

Is patient under the care of other physicians? _____ If yes, please list names:

_____

_____

List of previous medications:

_____

_____

List of current medications:

_____

_____