



Child and Adolescent Intake Form

This information is considered confidential and will not be released without written permission of parents and/or guardian. Please complete the form and provide details where possible.

PART I: Identifying Information

Child's Name: _____ D.O.B.: _____

Gender: _____ Telephone number: _____

Address: _____

Place of Birth/Hospital: _____

Mother's Name: _____ Phone: H: _____ W: _____

Father's Name: _____ Phone: H: _____ W: _____

Parents' marital status: Circle one: Married Divorced Separated Never Married Living Together

Who is the major caretaker of the child? _____

Private Insurance: _____ Group #: _____ Policy #: _____

Medicaid #, if applicable: _____

Person Completing From: _____ Relationship to Child: _____

Who referred you ? _____ May we send then a thank you note? Circle Yes No

May we send you information about our upcoming programs by mail or email? Circle Yes No

If yes by email list email address: _____

PART II: Reason for Referral

What is the main concern and what are some of the behaviors you observe that make you suspect there is a problem ? _____

Does the present problem occur at home? _____ school? _____ other? _____

Are there other concerns? _____

Social and Behavioral Questions

Place a check to any behavior or problem that your child currently exhibits:

- | | |
|---|--|
| <input type="checkbox"/> Has difficulty with speech
(articulation or producing sounds) | <input type="checkbox"/> Has frequent tantrums |
| <input type="checkbox"/> Has difficulty with hearing | <input type="checkbox"/> oppositional/defiant |
| <input type="checkbox"/> Has difficulty with language | <input type="checkbox"/> Has frequent nightmares |
| <input type="checkbox"/> Has difficulty with vision | <input type="checkbox"/> Has trouble sleeping |
| <input type="checkbox"/> Has poor bowel control | <input type="checkbox"/> Has poor appetite |
| <input type="checkbox"/> Has difficulty with coordination | <input type="checkbox"/> Has memory problems |
| <input type="checkbox"/> Wets bed | <input type="checkbox"/> Has attachment problems |
| <input type="checkbox"/> Is much too active | <input type="checkbox"/> Is aggressive |
| <input type="checkbox"/> Is distractible/short attention span | <input type="checkbox"/> Is slow to learn |
| <input type="checkbox"/> Is fearful | <input type="checkbox"/> Is impulsive |
| | <input type="checkbox"/> Does not get along with peers |

Please use this space to describe any problems in more detail: _____

Does he/she have a problem controlling his temper or with controlling anger? (describe) _____

Does he/she ever get sad or withdrawn? (describe) _____

How does this child react to stress and frustration? (describe) _____

Does the child seem more clumsy than other children? _____

Does the child have a hard time sitting still and paying attention to things? (describe) _____

Does the child have any problems interacting with peers out side the home? (describe) _____

How does the child get along with other family members? _____

Does his/her behavior cause difficulty within the family? _____

When was the problem first observed and by whom? _____

What was done at that time? _____

Has the child been evaluated for the current problem before? Circle: Yes No

If yes, when and by whom? _____

Has the child seen a psychiatrist or psychologist previously? Circle: Yes No

If yes, who _____ May I contact them for additional information? Circle: Yes No

If yes, list contact information _____

Please sign here giving authorization to contact this person: _____

Was it in reference to this or another problem? Same: _____ Different: _____

If different, please explain: _____

PART III: Family Information

Please list those persons who are important in your child's life.

Household Occupants	Age	Relationship	Occupation	Lives with child (yes/no)

Has your family ever had genetic studies done? Circle Yes No

Where and Why /Results: _____

Are there any other family members with similar problems to those discussed on this form?

Has anyone in the family of either parent had any of the following problems?

	Yes	No	Relationship to Child
Learning Problems in School	_____	_____	_____
Mental Retardation	_____	_____	_____
Sickle Cell	_____	_____	_____
Diabetes	_____	_____	_____
Blindness	_____	_____	_____
Seizures	_____	_____	_____
Alcoholism	_____	_____	_____
Depression	_____	_____	_____
Anxiety	_____	_____	_____
Birth Defect	_____	_____	_____
TB	_____	_____	_____
Cancer	_____	_____	_____
Deafness	_____	_____	_____
Cerebral Palsy	_____	_____	_____
OTHER:	_____	_____	_____

Is the child adopted? Circle Yes No How long has the child lived in the current home? _____

When was the child initially placed outside the birth home? _____)

Why? _____

How many placements has the child had? _____ What were you told about the child's history?

PART IV: Prenatal, Birth and Developmental History

During pregnancy, did the child's mother use any of the following:

___ Tobacco ___ Alcohol ___ Medications ___ Drugs

Weight at Birth: _____ Length at Birth: _____

Length of Labor: _____ Type of Delivery: Vaginal _____; C-Section _____

Any problems during the birth?: Y or N

Full Term: Y or N If not, how many weeks' gestation? _____

Did the child breathe on his/her own at birth? Y or N Was Oxygen required? Y or N

Explain: _____

This is a list of developmental milestones. Please give the approximate age when your child did reach the following. If the child cannot accomplish the item please indicate that by writing "no" in the space.

Finger fed	_____	Cooed	_____
Undressed completely	_____	Understood "no"	_____
Tie shoes	_____	Laughed aloud	_____
Toilet trained	_____	Gestures (waving bye, pat-a-cake)	_____
Rolled over	_____	Followed one command	_____
Sat unassisted	_____	(without you pointing)	_____
Crawled	_____	Said First Words	_____
Walked	_____	Put Two Words Together	_____
Points to 5 body parts (where are your eyes, etc.)	_____		

PART V: Medical History

Have there been any health problems? _____ If yes, please explain _____

Has he/she ever been hospitalized? _____

Has he/she ever had surgery? _____

When was the last eye exam? _____ Results: _____

When was the last hearing exam? _____ Results: _____

Does he/she have allergies? Y or N (please list) _____

Are his/her immunizations up to date? Y or N

Medications: Please list any medications your child currently takes regularly?

Name	Frequency	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician name: _____ Telephone number: _____

Physician name: _____ Telephone number: _____

May I contact the physician to coordinate care if necessary? Circle Yes No

If yes, please sign giving authorization to contact them: _____

PART VI: Educational History

Name of school: _____ Grade: _____ Special Ed Services: Circle: YES NO

Has the child had any educational testing? Circle: YES NO

What grades does the child typically earn? _____

Does the child receive: speech therapy _____ occupational therapy _____ physical therapy _____

If so, what type, where and when? (date of last assessment) _____

Has the child been held back in a grade? Circle Yes No

Number of schools the child has attended _____

Place a check next to any educational problem that the child currently exhibits

- | | |
|--|-----------------------------------|
| _____ Has difficulty with reading | _____ Has behavior problems |
| _____ Has difficulty with arithmetic | _____ Does not like school |
| _____ Has difficulty with spelling | _____ Has difficulty with writing |
| _____ Does not get along with classmates | |

PART VII: Employment History

Has the child ever been employed? Circle Yes No

If yes, give details _____

PART VIII: Legal History

Has the child ever had difficulty with the police? Circle Yes No If yes, explain _____

Has the child ever appeared in juvenile court? Circle Yes No If yes, explain _____

Has the child ever been on probation? Circle Yes No
If yes, give dates, reason, and name of probation officer _____

To your knowledge has the child ever used drugs or alcohol? Circle Yes No If yes, explain _____

Part IX: Other Information

What are the child's strengths? _____

What are the child's favorite activities? _____

What is the child's temperament like? _____

Please discuss anything else it would be important to know about the child: _____

For Professional Use Only
