

Dear Parent/Guardian,

Please fill out this form in as much detail as possible. We appreciate your taking time to provide us with this information which will help us understand your concerns and make an accurate diagnosis.

CHILD INTAKE/HISTORY

Name of person completing the form _____

Last

First

Relationship to the Child _____

Child's Name _____

Last

First

Middle Initial

Age _____ Date of Birth _____ / _____ / _____ Place of Birth _____

(mm/dd/yyyy)

City/US State/Country

Grade _____ School _____

Home Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Alternate Phone Number _____

Emergency Contact Person's Name _____ Phone _____

FAMILY INFORMATION

Mother's Name _____

Age _____ Date of Birth _____ / _____ / _____ Occupation: _____

(mm/dd/yyyy)

Education _____

Phone (Home) _____ (Work) _____ (Cell) _____

Email Address _____

Age at time of Marriage _____ Age at time of Birth of Child _____

Father's Name _____

Age _____ Date of Birth _____ / _____ / _____ Occupation: _____

(mm/dd/yyyy)

Education_____

Phone (Home)_____(Work)_____(Cell)_____

Email Address_____

Age at time of Marriage_____Age at time of Birth of Child_____

*If parents living apart, other parent's: Home Phone Number_____

Street Address_____

City_____State_____Zip_____

Household Composition

Name (Last, First)	Age	Relationship	Education	Occupation

Family Members/Significant Others not in household

Name (Last, First)	Age	Relationship	Phone#	Occupation

How does your child get along with:

Mother?_____Father_____

Sister(s)?_____Brother(s)?_____

Is child living with both biological parents?

☐ Yes ☐ No

If not, please explain _____

MEDICAL AND HEALTH INFORMATION

Current Height _____ Current Weight _____

Has your child had any surgery, serious illnesses or accidents? ☐ Yes ☐ No

Does your child have allergies? (Environmental or food allergies) ☐ Yes ☐ No

Does your child have asthma or any other respiratory problems? ☐ Yes ☐ No

Does your child have any medical conditions? ☐ Yes ☐ No

If you answered yes to any of the above questions, please explain: _____

Does your child take any medications regularly? ☐ Yes ☐ No

If yes, please list: _____

Has your child ever been examined by:

Ear, Nose, and Throat Doctor? ☐ Yes ☐ No

Neurologist? ☐ Yes ☐ No

Psychologist? ☐ Yes ☐ No

Other Medical Specialist ☐ Yes ☐ No

If yes, please explain reason for visit and outcome: _____

Please give place and dates of any previous evaluations or therapy:

Hearing: _____

Vision: _____

Physical Therapy: _____

Occupational Therapy: _____

Speech/Language Therapy: _____

Psychotherapy: _____

Other: _____

Has your child's hearing ever been tested? ☐ Yes ☐ No

Results: ☐ Normal ☐ Hearing Impairment (please explain) _____

Does your child have a history of ear infections?

☐ None ☐ Rarely ☐ 1-2 times /year ☐ 3-4 times /year ☐ 5 or more times/year

What treatment was provided for your child's ear infections? _____

Has your child ever had tubes in his or her ears or other ear surgery? ☐ Yes ☐ No

If yes, please explain _____

Does your child have any vision problems? ☐ Yes ☐ No

If yes, Please explain _____

How would you describe your child's overall health? ☐ Good ☐ Poor

Pediatrician's name _____

Practice _____ Phone number: _____

PRENATAL HISTORY

While pregnant, did mother have:

a. High blood pressure ☐ Yes ☐ No

b. Excessive Vomiting ☐ Yes ☐ No

c. Bleeding or spotting ☐ Yes ☐ No

d. Kidney Disease ☐ Yes ☐ No

e. Toxemia ☐ Yes ☐ No

f. Gestational diabetes ☐ Yes ☐ No

g. Threatened Miscarriage ☐ Yes ☐ No

h. German Measles (Rubella) ☐ Yes ☐ No

- i. Illness other than cold or flu ☐ Yes ☐ No
- j. Hospitalization Required ☐ Yes ☐ No
- k. Premature labor ☐ Yes ☐ No
- Was there any substance/alcohol abuse? ☐ Yes ☐ No
- If yes, please explain_____

Did mother take any medications during pregnancy ☐ Yes ☐ No

If yes, please explain_____

BIRTH HISTORY

Where was baby born: _____

Was labor induced: ☐ Yes ☐ No

Was labor helped by medication: ☐ Yes ☐ No

Duration of labor: _____

Was baby born early: (less than 38 weeks) ☐ Yes ☐ No

Was baby born late (after 42 weeks) ☐ Yes ☐ No

What was the method of delivery?

☐ Spontaneous vaginal	☐ Forceps
☐ Breech	☐ Caesarean

Reason_____

Birth weight of baby:_____

During hospital stay, did baby have any of the following:

- a. Jaundice ☐ Yes ☐ No
- b. Antibiotic treatment ☐ Yes ☐ No
- c. Rash ☐ Yes ☐ No
- d. Blue spells ☐ Yes ☐ No

e. Convulsions

☐ Yes ☐ No

f. Remain in hospital longer than mother

☐ Yes ☐ No

g. Incubator Care

☐ Yes ☐ No

h. Infection

☐ Yes ☐ No

DEVELOPMENTAL HISTORY

Approximate age at which your child reached these developmental milestones:

	Age	If exact age not known; it occurred		
		Early	Late	Normal
Hold up head				
Roll over				
Sit unsupported				
Respond to Own Name				
Crawled				
Stand alone				
Walk				
Talk				
Toilet train				
Feed her/himself				
Dress her/himself				
Jump				
Ride a Tricycle				
Read				
Throw & Catch a Ball				
Name Colors				

Please mark any areas which constitute a problem for your child:

- | | |
|---|--|
| a. Eating | ☐ Yes ☐ No |
| b. Sleeping | ☐ Yes ☐ No |
| c. Nightmares | ☐ Yes ☐ No |
| d. Thumb sucking | ☐ Yes ☐ No |
| e. Nail biting | ☐ Yes ☐ No |
| f. Bedwetting | ☐ Yes ☐ No |
| g. Getting along with friends | ☐ Yes ☐ No |
| h. Self-help skills (dressing, bathing, etc.) | ☐ Yes ☐ No |
| i. Understanding Directions | ☐ Yes ☐ No |
| j. Unusual fears (describe) | ☐ Yes ☐ No |
-
-

SCHOOL AND EDUCATIONAL INFORMATION

Age began daycare/nursery or preschool _____

Age started Kindergarten _____

Does your child refuse to go to school ☐ Yes ☐ No

Does your child enjoy school ☐ Yes ☐ No

Is your child in special classes? ☐ Yes ☐ No

If yes, please specify _____

Has your child ever repeated a grade? ☐ Yes ☐ No

If yes, which grade _____

Is there any family member (sibling, parent, grandparent, etc.) who presently or in the past have (or had) learning difficulties or was in special classes? ☐ Yes ☐ No

If yes, who and what kind/type? _____

Do you feel that your child is making progress at school ☐ Yes ☐ No

Are you satisfied with the school program for your child? ☐ Yes ☐ No

Briefly describe any academic problems that your child is facing at school _____

Does your child face trouble in these specific learning areas:

- | | |
|-------------------------------|--|
| a. Math | ☐ Yes ☐ No |
| b. Reading | ☐ Yes ☐ No |
| c. Writing | ☐ Yes ☐ No |
| d. Verbal/Oral Expression | ☐ Yes ☐ No |
| e. Understanding instructions | ☐ Yes ☐ No |

SOCIAL AND EMOTIONAL INFORMATION

List your child's major interest and hobbies _____

Is your child involved in extracurricular activities? ☐ Yes ☐ No

If yes, what kind _____

Friends (how many): _____ Age range _____

Briefly describe any behavioral problems that your child is facing at home/school _____

Are there any past or present circumstances which you think could be related to your child's present difficulties? _____

Has your child ever experienced any traumatic events (e.g., death of a close relative or friend, accident, etc.)? ☐ Yes ☐ No

If yes, please describe _____

Has your child ever had counseling, psychotherapy, or a psychological or psychiatric evaluation? ☐ Yes ☐ No

If yes, date(s) _____

Agency or name of therapist _____

Do any family members have (or have had) a psychological disorder? ☐ Yes ☐ No

If yes, who and what kind? _____

Please put any other comments that will help us understand your child better _____

CONSENT FOR TREATMENT

I voluntarily agree to and give consent for evaluation / treatment by Behavioral Care Services for myself and/or my family members.

Patient/Parent/Guardian Signature _____

Printed Name: _____

Date: _____