5. Child and Adolescent Intake Report

The following questionnaire is to be completed by the parent or guardian or adolescent if they would like. This form has been designed to provide necessary information to our staff before our initial conference in order to make the most productive and efficient use of our actual time together. As you complete this form, please feel free to add any additional information which you think may be helpful to us in understanding your child. All information provided by you is strictly confidential and will not be released to anyone without your written request.

General Information:

Person Completing Form: :

Child's Name: Date of Birth: Age: :

Home Address: :

City State Zip :

Primary phone number::

Secondary phone number:

Email:

School and Grade:

Who referred you to our office? :

Reason for referral/current symptoms

Please describe the problems your child is now having and the type of services you are seeking. :

Please indicate if your child is experiencing any of the following difficulties:

- [ ] School attention/concentration problems
- [ ] Grades dropping or consistently low
- [ ] Hyperactive, difficulty being still
- [ ] Impulsive, doesn't think before acting
- [ ] Sadness or Depression
- [ ] Generalized Anxiety (across many situations)
- [ ] Specific fears/phobia

if so, please list:

- [ ] Social Anxiety
- [ ] Obsessive-Compulsive / Rigid behavior patterns
- [ ] Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)
- [ ] Isolated socially from peers
- [ ] Problems making or keeping friends
- [ ] Problems with eating
- [ ] Problems falling asleep
- [ ] Problems sleeping through the night (middle of the night or early morning waking)
- [ ] Fatigue/tiredness during the day
- [ ] Nightmares
- [ ] Noncompliant, purposely does not obey (not due to language or cognitive deficits)
- [ ] Problems controlling temper
- [ ] Tantrums / "Meltdowns"
- [ ] Problems with authority (breaking rules or laws)
- [ ] Physically aggressive behavior towards others (biting, pinching, scratching, kicking, fighting)
- [ ] Verbally aggressive behavior towards others (name-calling, screaming, swearing, unkind comments)
- [ ] Self-injurious / Self-harm behavior (head banging, scratching, biting, cutting self)
- [ ] Wetting accidents (indicate day or night wetting):

☐ Soiling accidents or other bowel problems (withholding, refusal, fear/anxiety)

☐ History of abuse (emotional, physical, sexual)

☐ Alcohol or drug use/abuse

☐ Vocal or motor tics (e.g, grunts, squeals, eye blinks, throat clearing, grimacing, involuntary movements)

☐ Sensory problems (over-reacts or under-reacts to lights, sounds, tastes, textures, smells)

☐ Stress from conflict between parents

☐ Stress due to family

☐ Legal situation (anyone in family)

Other behavior problems: :

Parenets/Guardians and Family Information:

Mother's Name: Age: :

Occupation: :

Enter title:

Education Completed::

Health: _____Excellent _____Good _____Fair _____Poor :

Father's Name: Age: :

Occupation ::

Education completed ::

Health: _____Excellent _____Good _____Fair ____Poor :

Marital Status:

☐ Married

- [ ] Remarried
- [ ] Divorced
- [ ] Separated
- [ ] Widowed
- [ ] Single
- [ ] Cohabitants

If married, how long have you been married? :

If divorced, how long have you been divorced?:

Has either parent been married before or since? Mother: Father:

If yes, provide dates of other marriage(s), names, and ages of children from these marriages:

Mother: Children and ages: :

Father: Children and ages: :

Is there a birth parent living outside the home:

- [ ] Mother
- [ ] Father

Where does this parent live? :

If birth parent(s) do/does not live in the child's home, how much contact does the child have with the parent(s) not having custody, with stepsiblings, etc.? :

How would you rate the quality of your present marriage?

Mother: Great, Very Good, Good ,Fair, Poor ,Very Poor :

Father: Great, Very Good, Good ,Fair, Poor ,Very Poor :

Does either parent's job require him/her to be away from home long hours or extended periods? If yes, explain: :

Siblings: List IN ORDER OF AGE siblings of child/adolescent for whom you are seeking services.

Sibling name, age, grade,and school:

Sibling name, age, grade, and school:

Sibling name, age, grade,and school:

Sibling name, age, grade,and school:

Sibling name, age, grade, and school:

In general, how would you say the child for whom you are seeking services gets along with these siblings? Great Very Good Good Fair Poor Very Poor Describe: :

Are there other relatives who have a significant impact on how this child is raised? :

Please rate the overall level of FAMILY stress: _____Very Low _____Low _____Average _____High _____Very High :

What is the greatest source of stress for the family at this time? :

Please rate the overall level of stress in the mother's life: Very Low, Low, Average, High, Very High :

What are the greatest sources of stress in the mother's life? :

Please rate the overall level of stress in the father's life: Very Low, Low, Average, High, Very High :

What are the greatest sources of stress in the father's life? :

Family History

Has anyone in the birth family had any of the following psychological disorders? Check all that apply and list who.

☐ General Developmental Delays or Cognitive Delay

If yes: please list who:

☐ Speech or Communication Disorder

If yes: please list who:

☐ Intellectual Disability (mental retardation)

If yes: please list who:

☐ Attention-Deficit / Hyperactivity / Impulsivity

If yes: please list who:

☐ Learning Problems / Disabilities

If yes: please list who:

☐ Autism Spectrum / Asperger's Disorder

If yes: please list who:

☐ Sleep disorders

If yes: please list who :

☐ Generalized Anxiety (across many situations)

If yes: please list who:

☐ Social Anxieties

If yes: please list who:

☐ Obsessive-Compulsive Disorder

If yes: please list who:

☐ Phobias

If yes: please list who:

☐ Depression

If yes: please list who:

☐ Manic-Depression / Bipolar Disorder

If yes: please list who:

☐ Suicide attempts / Suicide

If yes: please list who:

☐ Schizophrenia or other psychosis

If yes: please list who:

☐ Alcohol / Substance Abuse

If yes: please list who:

☐ Seizures or other neurological disorder

If yes: please list who:

☐ Genetic Disorder (e.g., Down Syndrome, Fragile X)

If yes: please list who:

Other::

Is there a history in the immediate or extended family of any medical difficulties, illnesses or surgeries? Please list: :

Developmental History

Any difficulties during the pregnancy or delivery of this child? Please list any medications, periods of bed rest, etc. :

Child was born: premature, at full term, late :

Birth Weight lbs, oz :

Describe your child's temperament as an infant (e.g., easy-going, irritable, passive, difficult to soothe, etc.) :

Any medical problems diagnosed in infancy?:

As an infant, did this child seem: less active than average, average, overly active :

As a toddler, did this child seem: less active than average, average, overly active:

As a preschooler, did this child seem: less active than average, average, overly active:

As the child entered school, did this child seem: less active than average, average, overly active:

At what age did your child accomplish these developmental tasks? If your child has not met one or more milestones, leave those items blank or write "not yet."

Early On-Time Late Approximate age (if known)

Speech and Language

Coo/babble :

Respond to name:

Say first word:

Use gestures (wave, point) :

Put words together :

Speak in sentences:

Follow simple directions:

Follow multistep directions:

Motor Skills

Roll over:

Sit alone :

Stand alone :

Walk alone:

Write legibly :

Self-Help/Independence

Feed self:

Toilet train (bladder) :

Toilet train (bowel) :

Dress self:

Bathe self :

Social/Emotional

Smile at others:

Laugh aloud :

Show affection:

Engage in pretend play:

First friendship:

Control feelings when upset :

Understand others' feelings :

Show responsibility :

Medical History

Rate your child's overall health: Excellent, Good, Fair, Poor :

Does your child have any vision problems?:

Does your child have any hearing problems? :

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other medical conditions your child has had.:

List any medications your child is currently taking, including over-the-counter drugs, vitamins, and other nutritional supplements (include dosages). Also list previous medications and dates if taken for an extended period of time.:

What is your child's typical bedtime and wake time each day? Any concerns about your child's sleeping habits? :

Has your child had any previous psychological, psychiatric, or neurological examinations? If so, by whom, when, and what was your understanding of their findings? :

Educational and Social History

Has your child ever repeated a grade? If so, which? :

Has your child ever skipped a grade? If so, which? :

Has this child ever been in a Special Education Program? If so, during what years? If so what type of program(Gifted.LD, and so forth) :

Child's attitude toward school: :

How does your child interact with peers and adults in social situations? Do you have concerns about your child's social skills or development?:

List your child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.::

Describe your child's strengths, positive qualities, and any special abilities or skills:

Behavior Management/Discipline

Please rate what percentage of discipline is handled by each of the following: Father:_____% Mother:____% Other:____% (Please specify):_____ :

Please list the five things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sisters, etc. :

Please list all forms of discipline strategies used: (time out, send to room, take away privileges, take away material things, assign additional chore, ground child, Reason with child / Problem-Solve / Negotiate, yell at child, physical punishment) :

Enter titleHave you every filed or been involved in any litigation? Please explain :

Is there anything else we should know about your child that was not covered by this form? :