

Child Intake Form

Child's Given Name _____ Date of Birth _____

Developmental History:

Was pregnancy planned? Yes[] No[] Or is child adopted? Yes[] No[] Age at adoption _____

Describe any complications experienced during pregnancy _____

Describe any complications during birth & delivery _____

Any problems feeding? Yes[] No[] Age _____ Duration _____

Any problems eating? Yes[] No[] Describe _____

Any problems sleeping? Yes[] No[] Describe _____

Have there been any physical or emotional separations (i.e. death, hospitalizations) between child and caretaking adult during the first 26 months of life? Yes[] No[] If yes, explain _____

Is there any history that could be considered abusive? Yes[] No[] If yes, was it physical[], emotional[], sexual[]?

Age he/she: Held head up _____ Turned over _____ Sat _____ Pulled up _____

Smiled at parents _____ Crawled _____ Walked with help _____ Was weaned _____

Used sentences _____ Fed self _____ Helped dress self _____ Dressed alone _____

Dry during day _____ Dry during night _____

Is he/she: Impulsive _____ Timid or shy _____ Right/left handed _____

Stubborn _____ Well coordinated _____ Clumsy _____ Affectionate _____

Any previous testing or therapy? Yes[] No[]

Dates _____ Place _____

Finding _____

List any special problems that might have caused stress for your child _____

How did you choose this time to seek counseling? _____

School Information: (please fill in where appropriate)

School _____ Teacher _____

Grade _____ Year Enrolled _____ School Phone _____

Has child been: Tutored _____, In special class _____, Expelled _____, Suspended _____,

Repeated a grade _____, Cut classes _____.

The school has said my child: Is hyperactive _____, Is bored _____, Procrastinates _____,

Gets along well with adults _____, Gets along well with students _____,

Has few friends _____, IQ is above/below average _____.

Family Information: Who wanted help? _____

Five adjectives describing mother: _____

Five adjectives describing father: _____

Five adjectives describing parental relationship: _____

Personal Information:

Pediatrician _____ Pediatrician's phone _____

Address _____ City _____ St _____ Zip _____

List any present medical problems and current medications _____

Has child had counseling and/or psychiatric care? Yes[] No[] If yes, when _____

Doctor or counselor _____

Address _____ City _____ St _____ Zip _____

Behavioral Questionnaire for Parents or Guardians

This questionnaire is designed to help your child’s professional team understand the extent of behavioral issues. Such an understanding can help us with diagnosis, if any, and treatment planning. Please answer all questions, indicating the degree of the problem by where you place your check mark or “x”.

	Never	Rarely	Pretty much	Very much
1. Picks at things (nails, fingers, hair, clothing).				
2. Sassy to grown-ups.				
3. Problems with making or keeping friends.				
4. Excitable, impulsive.				
5. Wants to run things.				
6. Sucks or chews (thumb, clothing, hair, blanket).				
7. Cries easily or often.				
8. Carries a chip on his/her shoulder.				
9. Daydreams.				
10. Difficulty in learning.				
11. Restless in the “squirmy” sense.				
12. Fearful (of new situations; new people or places; going to school).				
13. Restless, always up and on the go.				
14. Destructive.				
15. Tells lies or stories that aren’t true.				
16. Shy.				
17. Gets into more trouble than others same age.				
18. Speaks differently from others same age (baby talk, stuttering, hard to understand).				
19. Denies mistakes or blames others.				
20. Quarrelsome.				
21. Pouts and sulks.				
22. Steals.				
23. Disobedient or obeys but resentfully.				
24. Worries more than others (about being alone, illness, or death).				
25. Fails to finish things.				
26. Feelings easily hurt.				
27. Bullies others.				
28. Unable to stop a repetitive activity.				
29. Cruel (to toys, animals, playmates).				
30. Childish or immature (wants help he/she shouldn’t need, clingy, needs reassurance).				
31. Distractibility or attention span a problem.				
32. Headaches.				
33. Mood changes quickly and drastically.				
34. Doesn’t like or doesn’t follow rules or restrictions.				
35. Fights with siblings, playmates, peers at school.				
36. Doesn’t get along well with brothers or sisters.				
37. Easily frustrated in efforts.				
38. Disturbs other children.				
39. Basically an unhappy child.				
40. Problems with eating (poor appetite, up between bites).				
41. Stomach aches.				
42. Problems with sleep (can’t fall asleep; up too early; up in the night).				
43. Other aches and pains.				
44. Vomiting or nausea.				
45. Feels cheated in family circle.				
46. Boasts and brags.				
47. Lets self be pushed around.				
48. Bowel problems (frequently loose; irregular habits; constipation).				

