# CHILD INTAKE

Child's Name: ______________________________________________________________

Date of Birth: ____________________ Age: ____________ Sex (circle one): M F

Home Address: _____________________________________________________________

Home Phone: _________________________ Alternative Phone Number: ____________________

## FAMILY DATA

Person filling out this form (circle one): Mother Father Stepmother Stepfather Grandparent Legal Guardian Other (please specify):_________________

Name of person(s) with legal custody of child: ____________________________________________

Mother's (or Primary Parent's) Name: _____________________________________ Age: ________

Occupation:________________________________________________________________

Father's (or Primary Parent's) Name: _____________________________________ Age: _________

Occupation: _______________________________________________________________

Status of biological parents: Never Married Married Separated Divorced Unknown

If parents are separated or divorced, or if there has been a death of a parent, how old was the child when the separation/divorce or death occurred? __________________________________________

List all people currently living in the home with the child:

| Name | Relationship to Child | Age |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

If any brothers/sisters are residing outside of the home, list their names and ages below.

_______________________________________________________________________________

_______________________________________________________________________________

Primary language spoken in the home: _________________________________________________

Other languages spoken in the home: __________________________________________________

## PRENATAL, DEVELOPMENTAL AND MEDICAL HISTORY

Did the child's mother receive routine prenatal care from a medical professional throughout the pregnancy? Yes No

Did the child's mother experience any prenatal health problems or concerns? Yes No
If yes, please explain: ____________________________________________________________
____________________________________________________________________________

Did the child's mother take any medications during the pregnancy? Yes No
If yes, list here and for what reason it was prescribed: ______________________________
____________________________________________________________________________

Did the child's mother smoke cigarettes during pregnancy? Yes No
If yes, how many cigarettes per day? ____________________________________________

Did the child's mother drink alcohol during pregnancy? Yes No
If yes, what type(s) of alcohol (beer, wine, liquor) was consumed?_______________________
Number of drinks ____________per (day, week, month, etc.) __________________________

Did the child's mother use any drugs during pregnancy? Yes No
If yes, what type(s) were used?__________________________________________________
Amount used _______________per (day, week, month, etc.) ___________________________

Were there any immediate health concerns for the mother or child at the time of birth?
____________________________________________________________________________
____________________________________________________________________________

Was a Caesarean section performed? Yes No

Was the child born premature? Yes No
If so, how premature? _______________

What was the child's birth weight? _______________________________________________

Were there any feeding or sleeping problems? Yes No
If yes, please describe: ______________________________________________________
____________________________________________________________________________

Was there any evidence of developmental delays in the child as an infant or toddler?
(Ex. lack of eye contact, delays in sitting up, crawling, walking, talking, etc.) Yes No
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Was there any evidence of problems in social development? (Ex. lack of interest in other children or social activities, odd or highly specified interests) Yes No
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Does the child have any history of major medical problems, diseases, or surgical procedures?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Has the child ever sustained a head injury? Has he/she ever been unconscious?
______________________________________________________________________________
______________________________________________________________________________

Does the child have any current medical problems?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Is the child currently on any medications to treat a medical condition? Yes No
If yes, please list the medications and the reason for which it was prescribed:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Has the child ever been hospitalized for medical reasons (circle one)? Yes No
If yes, when and for what reason(s)? _________________________________________________
______________________________________________________________________________

Does the child have any medication allergies/bad reactions? Yes No
If yes, please specify: _______________________________________________________
______________________________________________________________________________

**FAMILY MEDICAL/SUBSTANCE HISTORY**

Place a check mark next to any illness or condition that any member of the immediate family currently has or has had in the past. When you check an item, please specify the family member's relation to the child.

| Condition | Check if yes | Relation to child |
|---|---|---|
| Alcoholism | ____________ | ____________________________ |
| Drug Addiction | ____________ | ____________________________ |
| Cancer | ____________ | ____________________________ |
| Diabetes | ____________ | ____________________________ |
| Heart Problems | ____________ | ____________________________ |
| Depression | ____________ | ____________________________ |
| Anxiety/Nerves | ____________ | ____________________________ |
| Suicide Attempt | ____________ | ____________________________ |
| Other | ____________ | ____________________________ |

## EDUCATIONAL HISTORY

Child’s Current School: ____________________________________________________ Grade:________

Child’s School is (circle one): Public Private Other (please specify):__________________________

Please list all schools the child has attended:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Please place a check mark next to each problem that your child currently exhibits:
_____ Has difficulty with reading
_____ Has difficulty with math
_____ Has difficulty with spelling
_____ Has difficulty with writing
_____ Has difficulty with other subjects (please specify): _________________________
_____ Does not like school
_____ Refuses to go to school
_____ Bullies or is bullied by other children

Is the child in any special education class(es)? Yes No
If yes, please specify the type of class(es): ________________________________________________

Has the child ever been retained (held back) in any grade? Yes No
If yes, which grade(s) and why? ________________________________________________________

Has the child ever received tutoring or special instruction? Yes No
If yes, for what subjects and when? ______________________________________________________
_____________________________________________________________________________________

Has the child ever been suspended from school? Yes No
If yes, when and for what reason? _______________________________________________________
_____________________________________________________________________________________

Has the child ever been expelled from school? Yes No
If yes, when and for what reason? _______________________________________________________
_____________________________________________________________________________________

Has the child ever been evaluated for a learning disorder or giftedness? Yes No
If yes, what were the results of the evaluation? ____________________________________________
_____________________________________________________________________________________

Briefly describe the history of your child’s grades in school (B’s in math, C’s in science, etc.)
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

The child’s most recent performance on standardized testing (the FCAT) was:

Below grade level ______ At grade level _______ Above grade level ________

## PRESENTING PROBLEM

Briefly describe the child's current difficulties or reason for the evaluation today:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

How long has this been a concern for you? ____________________________________________

When did you first notice the current problem? ________________________________________

What seems to help the problem? _________________________________________________

What seems to make the problem worse? _____________________________________________

In what environment(s) is the presenting problem(s) an issue for the child?

Home ________ School _________ In public places __________

Has the child received prior evaluation or treatment for the current problem or similar problems (please circle one)? Yes No

If so, when and by whom did the child receive the evaluation/treatment?

Name of Service Provider Dates of Service
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Is the child currently on any medications to treat the presenting problem(s)? Yes No
If yes, please list the name of each medication and the reason for which it was prescribed:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Have any other medications been tried in the past? __________________________________

Has your child ever expressed a desire to harm or kill him/herself? Yes No

Has your child ever attempted to harm or kill him/herself? Yes No
If so, when and what method was used? _____________________________________________

Has your child ever been hospitalized for psychiatric reasons (circle one)? Yes No
If yes, what date(s) and for what reason? ____________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

## SOCIAL AND BEHAVIORAL CHECKLIST

Please put a check mark next to any problem that your child currently exhibits.

| | | | |
|---|---|---|---|
| Has difficulty with speech | | Has frequent tantrum | |
| Has difficulty with hearing | | Trouble sleeping | |
| Has difficulty with language | | Frequent nightmares | |
| Has difficulty with vision | | Is inattentive | |
| Has difficulty with coordination | | Rocks back and forth | |
| Prefers to be alone | | Bangs head | |
| Does not get along with others | | Holds breath | |
| Is aggressive | | Eats poorly | |
| Is shy or timid | | Is stubborn | |
| Is more interested in things/objects than people | | Is much to active (can't sit still) | |
| Engages in behavior that could be dangerous to self/others | | Doesn't seem to learn from past experience | |
| Has specific fears | | Is clumsy | |
| Has specific habits/mannerisms | | Has blank or staring spells | |
| Sucks thumb | | Is impulsive | |
| Bites nails | | Gives up easily | |
| Wets bed | | Is slow to learn | |
| Has poor bowel control (soils self) | | Engages in cruelty toward animals | |
| Restricts eating or vomits after eating | | Shows daredevil behavior | |
| Wants to be the center of attention | | Shows significant interest in fire | |
| Easily susceptible to peer influence/pressure | | Cuts or burns self on purpose | |
| Spends time mostly alone | | Frequently talks about death | |
| Spends significant time on the computer (not for school work) | | Threatens to kill self | |

Does the child have any friends? Yes No
If yes, does the child make good choices in friends? Yes No

Does the child appear to engage in age-appropriate social interaction? Yes No
If no, explain: ______________________________________________________________
______________________________________________________________________________

What are your child's favorite activities? ____________________________________________
______________________________________________________________________________
______________________________________________________________________________

What are your child's least favorite activities? _______________________________________
______________________________________________________________________________
______________________________________________________________________________

Briefly describe the disciplinary strategies used in the home: ___________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Which disciplinary strategy is most effective with your child? ______________________________

Which disciplinary strategy is least effective with your child? ______________________________

What are the child's personal strengths? ___________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

## OTHER INFORMATION

Please use the remaining space on this form to describe any additional issues or information that you feel is relevant to the current evaluation: _____________________________________________

___________________________________________________________________________

___________________________________________________________________________

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