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Child Intake Form

DATE OF INTAKE: _____
NAME: _____ SEX: _____
DATE OF BIRTH: _____ GRADE: _____
SCHOOL: _____
HOME ADDRESS: _____

HOME PHONE NUMBER: _____
NAME OF INFORMANT(S): _____
RELATIONSHIP TO CHILD: _____
CELLULAR PHONE: _____ WORK PHONE: _____
BETTER WAY TO REACH YOU? _____

I. REASON FOR REFERRAL:

Who referred you to us? _____

What do you perceive the problem to be? _____

What would you like us to help you determine: _____

Why now? _____

II. BACKGROUND INFORMATION

A. General background history

Name of Mother: _____

Education: _____

Profession: _____

Name of Father: _____

Education: _____

Profession: _____

List family members (siblings, other(s) living with child):

Relationship to child	Age	Gender	Lives at home?

B. Other pertinent background history

Parents' marital status? _____

If parents are not married, then:

Do you have a significant other? _____

Does s/he live with the family? _____

How do(es) the child(ren) get along with him/her? _____

If parent divorced or widowed:

When (how old was the child)? _____

Who has custody of the child? _____

Relationship with non-custodial parent: (How often does your child see him/her?) _____

Languages spoken other than English: _____

What do you consider your (your child's) main language? _____

C. Developmental History:

Pregnancy with child: _____

Delivery and perinatal complications (at term, induced, C-section?):

How was your child as a baby? _____

Developmental Milestones: (comment on any problems)

1. Motor _____
2. Language _____
3. Toilet trained (At what age? Accidents after toilet trained?) _____

D. Medical History:

1. Hospitalizations? _____

2. Chronic illnesses (asthma, diabetes, allergies, etc.)? _____

3. Allergies _____

4. Ear infections (When? Frequency?): _____

5. Other illnesses: _____

6. Accidents: _____

When? _____

How did it happen? _____

Loss of consciousness? _____ For how long? _____

History of past and present medications (do not include regular antibiotics for colds, etc.)

Medicine	Indication	Dosage	Duration of Treatment	Side Effects

E. School Information

Previous schools? _____

Why did your child change school? _____

When did school problems start? _____

Who first noticed problems? _____

What kind of problems is your child having in school? _____

What areas are the most difficult for him/her? _____

Did your child have a difficult time learning to read? _____

What are his grades? _____

Special placement in school? _____

Has your child has been evaluated in the past? _____

Reasons for evaluation: _____

Has your child received tutoring in the past? For what? For how long?: _____

Did it help or is it helping? _____

F. Social Life:

1. Does your child have many friends? _____

2. Does s/he fight a lot with them? _____

3. What kind of activities does your child do with her/his friends? _____

4. How does s/he get along with other children at school ? _____

6. What does your child do for fun? (activities, hobbies, sports, etc.)

Additional information that could help us understand your child better:

Do you have any questions for us? _____

