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CHILD/TEEN INTAKE FORM

Date: _____

Child's Full Name: _____ Preferred Name: _____

Sex assigned at birth: ☐ M ☐ F Gender Identity/Pronoun (optional): _____

Age: _____ Birthdate: _____ Birthplace: _____

Grade: _____ School: _____ City (School): _____

Primary Language: _____ Other Languages: _____

Person completing form: _____

Relationship to child: _____ Marital Status: _____

Home Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Email Address: _____

Emergency Contact Name and Number: _____

Who may I thank for your referral to my office? _____

What is the primary reason or concern that brought you to the office today?

_____

_____

Cancellation Policy: Appointments must be cancelled or rescheduled at least 72 business hours in advance for testing appointments, and 48 hours in advance for therapy appointments. Failure to provide this notice will result in a cancellation fee (e.g., $350 per hour), and any future appointments may require prepayment.

_____ _____

Parent Signature **Date**

FAMILY INFORMATION

Parent Name 1: _____ Age: _____

Occupation: _____ Education: _____

Phone #: _____

Parent Name 2: _____ Age: _____

Occupation: _____ Education: _____

Phone #: _____

Is child living with both parents? ☐ Yes ☐ No

If parents are living apart (or separated or divorced), is other parent aware that you are seeking psychological services for your child? ☐ Yes ☐ No

If child is not living with both biological parents, please describe living and visitation arrangements:

_____

_____

_____

Siblings

Name	**Sex**	**Age**	**School/Occupation**

Other Persons in the Home

Name	**Age**	**Relation**

DEVELOPMENTAL AND HEALTH INFORMATION

Pediatrician's name: _____ Office number: _____

Height: _____ Weight: _____

Medication (and dosage) taken at this time: _____

Date of last medical checkup? _____

What is your child's present health? ☐ Excellent ☐ Good ☐ Fair

Please explain: _____

Does your child have allergies? ☐ No ☐ Yes, list _____

Is there a history of ear infections? ☐ No ☐ Yes

If yes, list frequency: _____

Has your child ever had any head injuries (loss of consciousness), seizures, hospitalizations or surgery? If yes, please explain:

_____

_____

_____

Approximate weight at birth: _____ Gestational Age (weeks): _____

Please check type of delivery: ☐ Vaginal ☐ C-Section

Mother's age at delivery: _____ Health during pregnancy: _____

Describe any complications during pregnancy or birth:

_____

_____

_____

Please indicate **E** (Early), **T** (Typical), **L** (Late) or **U** (Unknown) in describing when your child reached the following milestones:

_____ Sitting alone _____ Crawling _____ Standing alone

_____ Walking alone _____ Spoke first words _____ Spoke short sentences

When was your child able to stay dry during daytime? _____ Nighttime? _____

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

☐ Sadness/Low Mood ☐ Irritability/Anger ☐ Excessive Worry/Anxiety

☐ Eating/Appetite ☐ Thumb sucking ☐ Self-help skills (dressing, hygiene, etc.)

☐ Sleeping ☐ Nail biting ☐ Getting along with friends/Social Withdrawal

☐ Nightmares ☐ Unusual fears (describe) _____

☐ Other _____

Sensory Motor – Please check any areas of difficulty that apply to your child:

☐ Visual
☐ Hearing
☐ Wears glasses
☐ Wears hearing aid
☐ Accident prone/clumsy
☐ Has pressure equalization tubes
☐ Fine motor coordination
☐ Gross motor coordination
☐ Sensory Processing, if yes…

Sensitivity to:

_____ Loud sounds _____ Tactile _____ Smell
_____ Light/Dark _____ Temperature _____ Other

Does your child receive any services at this time?

☐ Speech/language therapy
☐ Occupational therapy
☐ Physical therapy
☐ Psychological therapy
☐ Psychiatric
☐ Other: _____

If yes, Provider name: _____

SCHOOL AND EDUCATIONAL HISTORY

Age began daycare, nursery, or preschool: _____ Age started Kindergarten: _____

Has your child ever repeated a grade/retained? ☐ No ☐ Yes Which grade? _____

List schools your child has attended:

Name	**City**	**Years/Grade(s)**

Is your child in special classes? ☐ No ☐ Yes If yes, what kind? _____

Name of zoned public school: _____

Is there any family member who presently or in the past have (had) learning and/or attention difficulties, or was in special classes? ☐ No ☐ Yes

If yes, who and what kind/type? _____

For children in K-12, what kind of grades does your child typically earn? _____

Describe any problems your child might be having in school and when you first noticed these problems:

In what school situations or subjects does your child perform best? Worst?

PSYCHOSOCIAL FUNCTIONING

List your child's major interests and hobbies:

_____

_____

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

If yes, what kind? _____

When interacting with same-aged peers, your child can be described as:

_____ Withdrawn	_____ Disinterested	_____ Assertive	_____ Aggressive
_____ Shy	_____ Anxious	_____ Engaging	_____ Friendly
_____ Thoughtful	_____ Leader	_____ Follower	_____ Bossy

How many friends does your child have? # Male: _____ # Female: _____

Do any family members have a history of mental health concerns? ☐ No ☐ Yes

If yes, who and what kind? _____

Please share any other comments that will help me understand your child better:

_____

_____

_____

_____

_____

_____

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_____

_____