

Dear Parent/Guardian,

Please fill out this form in as much detail as possible. We appreciate your taking time to provide us with this information which will help us understand your concerns and make an accurate diagnosis.

CHILD INTAKE/HISTORY

Name of person completing the form _____
Last First

Relationship to the Child _____

Child's Name _____
Last First Middle Initial

Age _____ Date of Birth / / Place of Birth _____
(mm/dd/yyyy) City/US State/Country

Grade _____ School _____

Home Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Alternate Phone Number _____

Emergency Contact Person's Name _____ Phone _____

FAMILY INFORMATION

Mother's Name _____

Age _____ Date of Birth / / Occupation: _____
(mm/dd/yyyy)

Education _____

Phone (Home) _____ (Work) _____ (Cell) _____

Email Address _____

Age at time of Marriage _____ Age at time of Birth of Child _____

Father's Name _____

Age _____ Date of Birth / / Occupation: _____
(mm/dd/yyyy)

Education _____

Phone (Home) _____ (Work) _____ (Cell) _____

Email Address _____

Age at time of Marriage _____ Age at time of Birth of Child _____

*If parents living apart, other parent's: Home Phone Number _____

Street Address _____

City _____ State _____ Zip _____

Household Composition

Name (Last, First)	Age	Relationship	Education	Occupation

Family Members/Significant Others not in household

Name (Last, First)	Age	Relationship	Phone#	Occupation

How does your child get along with:

Mother? _____ Father _____

Sister(s)? _____ Brother(s)? _____

Is child living with both biological parents? Yes No

If not, please explain _____

MEDICAL AND HEALTH INFORMATION

Current Height _____ Current Weight _____

Has your child had any surgery, serious illnesses or accidents? Yes No

Does your child have allergies? (Environmental or food allergies) Yes No

Does your child have asthma or any other respiratory problems? Yes No

Does your child have any medical conditions? Yes No

If you answered yes to any of the above questions, please explain: _____

Does your child take any medications regularly? Yes No

If yes, please list: _____

Has your child ever been examined by:

Ear, Nose, and Throat Doctor? Yes No

Neurologist? Yes No

Psychologist? Yes No

Other Medical Specialist Yes No

If yes, please explain reason for visit and outcome: _____

Please give place and dates of any previous evaluations or therapy:

Hearing: _____

Vision: _____

Physical Therapy: _____

Occupational Therapy: _____

Speech/Language Therapy: _____

Psychotherapy: _____

Other: _____

Has your child's hearing ever been tested? Yes No

Results: Normal Hearing Impairment (please explain) _____

Does your child have a history of ear infections?

None Rarely 1-2 times /year 3-4 times /year 5 or more times/year

What treatment was provided for your child's ear infections? _____

Has your child ever had tubes in his or her ears or other ear surgery? Yes No

If yes, please explain _____

Does your child have any vision problems? Yes No

If yes, Please explain _____

How would you describe your child's overall health? Good Poor

Pediatrician's name _____

Practice _____ Phone number: _____

PRENATAL HISTORY

While pregnant, did mother have:

a. High blood pressure Yes No

b. Excessive Vomiting Yes No

c. Bleeding or spotting Yes No

d. Kidney Disease Yes No

e. Toxemia Yes No

f. Gestational diabetes Yes No

g. Threatened Miscarriage Yes No

h. German Measles (Rubella) Yes No

- i. Illness other than cold or flu Yes No
 - j. Hospitalization Required Yes No
 - k. Premature labor Yes No
- Was there any substance/alcohol abuse? Yes No

If yes, please explain _____

Did mother take any medications during pregnancy Yes No

If yes, please explain _____

BIRTH HISTORY

Where was baby born: _____

Was labor induced: Yes No

Was labor helped by medication: Yes No

Duration of labor: _____

Was baby born early: (less than 38 weeks) Yes No

Was baby born late (after 42 weeks) Yes No

What was the method of delivery?

Spontaneous vaginal

Forceps

Breech

Caesarean

Reason _____

Birth weight of baby: _____

During hospital stay, did baby have any of the following:

a. Jaundice Yes No

b. Antibiotic treatment Yes No

c. Rash Yes No

d. Blue spells Yes No

- e. Convulsions Yes No
- f. Remain in hospital longer than mother Yes No
- g. Incubator Care Yes No
- h. Infection Yes No

DEVELOPMENTAL HISTORY

Approximate age at which your child reached these developmental milestones:

	Age	If exact age not known; it occurred		
		Early	Late	Normal
Hold up head				
Roll over				
Sit unsupported				
Respond to Own Name				
Crawled				
Stand alone				
Walk				
Talk				
Toilet train				
Feed her/himself				
Dress her/himself				
Jump				
Ride a Tricycle				
Read				
Throw & Catch a Ball				
Name Colors				

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

- a. Eating Yes No
 - b. Sleeping Yes No
 - c. Nightmares Yes No
 - d. Thumb sucking Yes No
 - e. Nail biting Yes No
 - f. Bedwetting Yes No
 - g. Getting along with friends Yes No
 - h. Self-help skills (dressing, bathing, etc.) Yes No
 - i. Understanding Directions Yes No
 - j. Unusual fears (describe) Yes No
-
-

SCHOOL AND EDUCATIONAL INFORMATION

Age began daycare/nursery or preschool _____

Age started Kindergarten _____

Does your child refuse to go to school Yes No

Does your child enjoy school Yes No

Is your child in special classes? Yes No

If yes, please specify _____

Has your child ever repeated a grade? Yes No

If yes, which grade _____

Is there any family member (sibling, parent, grandparent, etc.) who presently or in the past have (or had) learning difficulties or was in special classes? Yes No

If yes, who and what kind/type? _____

Do you feel that your child is making progress at school Yes No

Are you satisfied with the school program for your child? Yes No

Briefly describe any academic problems that your child is facing at school _____

Does your child face trouble in these specific learning areas:

- | | | |
|-------------------------------|------------------------------|-----------------------------|
| a. Math | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Reading | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Writing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Verbal/Oral Expression | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Understanding instructions | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

SOCIAL AND EMOTIONAL INFORMATION

List your child's major interest and hobbies _____

Is your child involved in extracurricular activities? Yes No

If yes, what kind _____

Friends (how many): _____ Age range _____

Briefly describe any behavioral problems that your child is facing at home/school _____

Are there any past or present circumstances which you think could be related to your child's present difficulties? _____

Has your child ever experienced any traumatic events (e.g., death of a close relative or friend, accident, etc.)? Yes No

If yes, please describe _____

Has your child ever had counseling, psychotherapy, or a psychological or psychiatric evaluation? Yes No

If yes, date(s) _____

Agency or name of therapist _____

Do any family members have (or have had) a psychological disorder? Yes No

If yes, who and what kind? _____

Please put any other comments that will help us understand your child better _____

CONSENT FOR TREATMENT

I voluntarily agree to and give consent for evaluation / treatment by Behavioral Care Services for myself and/or my family members.

Patient/Parent/Guardian Signature _____

Printed Name: _____

Date: _____