



CHILD PATIENT INTAKE FORM

(Please Print Clearly)

| FAMILY INFORMATION: List all family and household members | | | | |
|--|---------------|--|------------------|--|
| Name | Relationship | Age | Occupation/Grade | Residing w/you |
| | | | | <input type="radio"/> Yes <input type="radio"/> No |
| | | | | <input type="radio"/> Yes <input type="radio"/> No |
| | | | | <input type="radio"/> Yes <input type="radio"/> No |
| | | | | <input type="radio"/> Yes <input type="radio"/> No |
| | | | | <input type="radio"/> Yes <input type="radio"/> No |
| | | | | <input type="radio"/> Yes <input type="radio"/> No |
| | | | | <input type="radio"/> Yes <input type="radio"/> No |
| PARENTS MARITAL/RELATIONSHIP HISTORY: List all marital or partner relationships including present: | | | | |
| Name of Spouse/Partner | Date Married | Terminated by | Date | |
| | | <input type="radio"/> Divorce <input type="radio"/> Death <input type="radio"/> Separation | | |
| | | <input type="radio"/> Divorce <input type="radio"/> Death <input type="radio"/> Separation | | |
| | | <input type="radio"/> Divorce <input type="radio"/> Death <input type="radio"/> Separation | | |
| | | <input type="radio"/> Divorce <input type="radio"/> Death <input type="radio"/> Separation | | |
| Family History: | Age if Living | Age at Death | Date of Death | Cause of Death |
| Father | | | | |
| Mother | | | | |
| Sister #1 | | | | |
| Sister #2 | | | | |
| Sister #3 | | | | |
| Sister #4 | | | | |
| Brother #1 | | | | |
| Brother #2 | | | | |
| Brother #3 | | | | |
| Brother #4 | | | | |



| | |
|--|-------------|
| How does the child get along with: | |
| Mother: | Father: |
| Sister(s): | Brother(s): |
| Who is the child closest with in the family? | |
| Who disciplines the child? | How? |
| | |
| Usually for what reason? | |
| | |
| Do the parents differ on discipline? <input type="radio"/> Yes <input type="radio"/> No If yes, please explain: | |
| | |
| | |
| The child spends most of his/her time: <input type="radio"/> Alone <input type="radio"/> with younger children <input type="radio"/> with children same age <input type="radio"/> with adults | |
| What are the child's major interests or hobbies? | |
| | |
| | |
| Do you feel your child is having difficulties at home? <input type="radio"/> Yes <input type="radio"/> No If yes, please explain: | |
| | |
| | |
| When and how did this problem begin? | |
| | |
| Are there any past or present family problems that may have contributed to the child's difficulties? <input type="radio"/> Yes <input type="radio"/> No | |
| If yes, please explain: | |
| | |



PREGNANCY, BIRTH AND DEVELOPMENT HISTORY

Were there complications during pregnancy? Yes No If yes, please explain:

Pregnancy: Months **Birth Weight:** Pounds Ounces

Please describe mother's and child's health during and after birth:

Age First: Sat up Walked Toilet Trained

Spoke 1st words Spoke Sentences

If adopted, does child know: Yes No

MEDICAL DATA

Childhood Illness (check all that apply):

- High Fevers Seizures Measles Meningitis
- Ear Infections Accidents Mumps Mono
- Frequent Colds Head Injuries Chicken Pox Other

Hospitalization (Please list age during hospitalization and reason):

1.

2.

3.

Has your child ever had problems in the following areas? if yes, explain:

Hearing Does child wear a hearing aid? Yes No

Vision Does child wear glasses? Yes No

Speech



Does child have allergies? Yes No If yes, please list:

Is child presently taking any medications? Yes No If yes, please list:

Child's physician:

Date of last exam:

Check any of the following which present a problem for your child and explain below:

- | | | | |
|---------------------------------------|-----------------------------------|-------------------------------------|---|
| <input type="radio"/> Eating | <input type="radio"/> Sleeping | <input type="radio"/> Nail biting | <input type="radio"/> Toilet accidents |
| <input type="radio"/> Over active | <input type="radio"/> Nightmares | <input type="radio"/> Thumb sucking | <input type="radio"/> Dressing, bathing |
| <input type="radio"/> Temper tantrums | <input type="radio"/> Daydreaming | <input type="radio"/> Unusual fears | <input type="radio"/> Bed wetting |

Getting along with Friends Family Others:

Explain:

Has child ever had any of the following?

Psychological exam: Yes No If yes, please list date

Psychiatric exam: Yes No If yes, please list date

Neurological exam: Yes No If yes, please list date

Counseling: Yes No If yes, please list date

EDUCATION HISTORY

List schools attended by child (include nursery and kindergarten if applicable):

1.

2.

3.

4.

Age started kindergarten:



Has child repeated any grade? Yes No If yes, please list

What are child's feelings toward school?

What are your feelings about your child's current educational program?

Do you feel your child is having difficulties in school? Yes No If yes, please explain:

When and how did this problem begin?

Are there any past or present family problems that may have contributed to the child's difficulties? Yes No

If yes, please explain:

Please list any additional information you feel may be helpful in understanding your child:

Printed name

Parent/Legal Guardian Signature

Date

Printed name

Parent/Legal Guardian Signature

Date