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 ☐ Yes ☐ No
b. Reading ☐ Yes ☐ No
c. Writing ☐ Yes ☐ No
d. Verbal/Oral Expression ☐ Yes ☐ No
e. Understanding instructions ☐ Yes ☐ 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:____