COLLABORATIVE COUNSELING CENTER
Working together to inspire change and promote growth

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Parent Intake Form

GENERAL INFORMATION

Patient Name: _____DOB: _____ Preferred Gender and Pronouns: _____

Person(s) completing the form: _____ Relationship to Patient: _____

What issues are you seeking help for at this time? _____

_____

_____

_____

_____

_____

When did you first notice these issues? _____

What things did you first notice? _____

_____

_____

Was the onset (circle one): Sudden or Gradual

Please describe any event(s) or action(s) that you or others think might have contributed to these issues (be as detailed as possible): _____

_____

_____

_____

What are your goals for the current treatment/evaluation? _____

_____

_____

_____

CURRENT BEHAVIOR

Which of the following are concerns you have about the child? (all that apply)

RELATIONSHIPS

- ☐ Problems getting along with family
- ☐ Problems getting along with peers
- ☐ Hard time talking to peers in some situations
- ☐ Hard time talking to non-family adults
- ☐ Difficulty understanding jokes
- ☐ Poor eye contact
- ☐ Self-conscious; Fear of embarrassment; Shy
- ☐ Uncomfortable socially
- ☐ Fear of social situations
- ☐ Sensitive to crowds
- ☐ Stubborn
- ☐ Distrustful; Suspicious; Secretive
- ☐ Lying; Sneaking
- ☐ Frequent arguing
- ☐ Oppositional/defiant
- ☐ Temper tantrums; Explosive episodes

EXTERNALIZING/DISRUPTIVE

- ☐ Acting violently
- ☐ Fire setting
- ☐ Rule breaking
- ☐ Property destruction
- ☐ Stealing
- ☐ Cruelty to animals
- ☐ Running away
- ☐ Risk taking behavior
- ☐ Alcohol abuse
- ☐ Other substance abuse
- ☐ Abuse perpetrator

MOOD

- ☐ Self-esteem problems
- ☐ Immaturity
- ☐ Angry; Aggressive
- ☐ Irritable
- ☐ Self-destructive/self-abusive behaviors
- ☐ Suicidal talk/thoughts of killing self
- ☐ Suicidal behaviors; Has hurt or cut self
- ☐ Depression/depressed mood/sadness
- ☐ Tearful crying spells
- ☐ Feeling hopeless, helpless, and/or worthless
- ☐ Grief/loss
- ☐ Lack of energy; Fatigue
- ☐ Withdrawn
- ☐ Lack of motivation
- ☐ Not enjoying usual activities
- ☐ Difficulty making decisions
- ☐ Difficulty planning ahead
- ☐ Overwhelmed/stressed
- ☐ Feeling guilty
- ☐ Moods change quickly
- ☐ Change in personality
- ☐ Excessively good/grandiose mood; Euphoria
- ☐ Excess energy
- ☐ Little sleep but not tired; Decreased need for sleep
- ☐ Racing thoughts; Flight of ideas
- ☐ Blackouts
- ☐ Hallucinations; Delusions
- ☐ Strange ideas or behaviors
- ☐ Poor awareness of time

ANXIETY

- ☐ Anxiety
- ☐ Panic attacks
- ☐ Obsessions or compulsions
- ☐ Perfectionism
- ☐ Rigid/inflexible
- ☐ Repetitive behaviors
- ☐ Head banging; Rocking
- ☐ Skin-picking
- ☐ Hair pulling
- ☐ Gets frustrated easily
- ☐ Abuse victim; Trauma history
- ☐ Worried
- ☐ Fear of bedtime
- ☐ Nightmares

LANGUAGE AND LEARNING

- ☐ Stuttering
- ☐ Involuntary vocalizations
- ☐ Resistance to school
- ☐ Learning problems; Language problems
- ☐ Trouble concentrating; Memory problems; Disorganization
- ☐ Difficulty following directions
- ☐ Difficulty getting started on tasks
- ☐ Difficulty staying on one task for a long time
- ☐ Difficulty with finishing a task; Difficulty completing homework
- ☐ Distractible; Gets easily distracted
- ☐ Difficulty with transitions
- ☐ Difficulty listening
- ☐ Impulsiveness
- ☐ Bouts of excessive energy; Always in motion; Excessively fidgety; Hyperactive
- ☐ Talkative
- ☐ Poor judgment
- ☐ Poor handwriting

PHYSICAL

- ☐ Tics/twitching
- ☐ Been pregnant
- ☐ Had an abortion; Partner had an abortion
- ☐ Sexual problems
- ☐ Dizziness; Seizures
- ☐ Pain/body complaints
- ☐ Sensory issues
- ☐ Blank spells; Fainting spells
- ☐ Bed wetting; Soiling
- ☐ Breath holding
- ☐ Change in sleep habits; Difficulty sleeping; Difficulty waking
- ☐ Change in eating habits/appetite; Significant weight changes
- ☐ Eating problems; Overeating; Eating too little; Eating disorder
- ☐ Eats paint, paper, etc.
- ☐ Nail biting; Thumb sucking
- ☐ Toileting problems
- ☐ Uncoordinated; Clumsy using hands; Clumsy walking
- ☐ Frequent urinary accidents

If you have other concerns not listed above, please note them here: _____

_____

_____

If any of the above behaviors were significant issues which have now gone away, please describe: _____

_____

_____

Please note the degree of impairment in the child's:	**None**	**Mild**	**Moderate**	**Marked**	**Extreme**
Family relationships	☐	☐	☐	☐	☐
School performance	☐	☐	☐	☐	☐
Friendships/Peer relationships	☐	☐	☐	☐	☐
Hobbies/Play activities	☐	☐	☐	☐	☐
Daily self-care	☐	☐	☐	☐	☐
Physical health	☐	☐	☐	☐	☐
Eating habits	☐	☐	☐	☐	☐
Sleeping habits	☐	☐	☐	☐	☐

Overall, how concerned are you with the child's behavior over the last few months? (please circle)

Not at All Mildly Moderately Extremely

Please note any important additional information regarding the child's current behaviors:

_____

_____

_____

_____

SYMPTOM SCREENING

Please enter the name of the person filling out this form: _____

What is your relationship to the patient (e.g., parent, guardian, teacher)? _____

Directions for questions 1-55: Each rating should be considered in the context of what is appropriate for the age of the child. When completing these 55 questions, please think about the child's behaviors in the past 6 months.

	Was on Medication	Was Not on Medication	Not Sure?
Is this evaluation based on a time when the child	☐	☐	☐

	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	☐	☐	☐	☐
2. Has difficulty keeping attention to what needs to be done	☐	☐	☐	☐
3. Does not seems to listen when spoken to directly	☐	☐	☐	☐
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	☐	☐	☐	☐
5. Has difficulty organizing tasks and activities	☐	☐	☐	☐
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	☐	☐	☐	☐
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	☐	☐	☐	☐
8. Is easily distracted by noises or other stimuli	☐	☐	☐	☐
9. Is forgetful in daily activities	☐	☐	☐	☐
10. Fidgets with hands or feet or squirms in seat	☐	☐	☐	☐
11. Leaves seat when remaining seated is expected	☐	☐	☐	☐
12. Runs about or climbs too much when remaining seated is expected	☐	☐	☐	☐
13. Has difficulty playing or beginning quiet play activities	☐	☐	☐	☐
14. Is "on the go" or often acts as if "driven by a motor"	☐	☐	☐	☐
15. Talks too much	☐	☐	☐	☐
16. Blurts out answers before questions have been completed	☐	☐	☐	☐

	Never	Occasionally	Often	Very Often
17. Has difficulty waiting his or her turn	☐	☐	☐	☐
18. Interrupts or intrudes in on others' conversations and/or activities	☐	☐	☐	☐
19. Argues with adults	☐	☐	☐	☐
20. Loses temper	☐	☐	☐	☐
21. Actively defies or refuses to go along with adults' requests or rules	☐	☐	☐	☐
22. Deliberately annoys people	☐	☐	☐	☐
23. Blames others for his or her mistakes or misbehaviors	☐	☐	☐	☐
24. Is touchy or easily annoyed by others	☐	☐	☐	☐
25. Is angry or resentful	☐	☐	☐	☐
26. Is spiteful and wants to get even	☐	☐	☐	☐
27. Bullies, threatens, or intimidates others	☐	☐	☐	☐
28. Starts physical fights	☐	☐	☐	☐
29. Lies to get out of trouble or to avoid obligations (i.e., "cons" others)	☐	☐	☐	☐
30. Is truant from school (skips school) without permission	☐	☐	☐	☐
31. Is physically cruel to people	☐	☐	☐	☐
32. Has stolen things that have value	☐	☐	☐	☐
33. Deliberately destroys others' property	☐	☐	☐	☐
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	☐	☐	☐	☐
35. Is physically cruel to animals	☐	☐	☐	☐
36. Has deliberately set fires to cause damage	☐	☐	☐	☐
37. Has broken into someone else's home, business, or car	☐	☐	☐	☐
38. Has stayed out at night without permission	☐	☐	☐	☐
39. Has run away from home overnight	☐	☐	☐	☐

	Never	Occasionally	Often	Very Often
40. Has forced someone into sexual activity	☐	☐	☐	☐
41. Is fearful, anxious, or worried	☐	☐	☐	☐
42. Is afraid to try new things for fear of making mistakes	☐	☐	☐	☐
43. Feels worthless or inferior	☐	☐	☐	☐
44. Blames self for problems, feels guilty	☐	☐	☐	☐
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	☐	☐	☐	☐
46. Is sad, unhappy, or depressed	☐	☐	☐	☐
47. Is self-conscious or easily embarrassed	☐	☐	☐	☐

	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	☐	☐	☐	☐	☐
49. Reading	☐	☐	☐	☐	☐
50. Writing	☐	☐	☐	☐	☐
51. Mathematics	☐	☐	☐	☐	☐
52. Relationship with parents	☐	☐	☐	☐	☐
53. Relationship with siblings	☐	☐	☐	☐	☐
54. Relationship with peers	☐	☐	☐	☐	☐
55. Participation in organized activities (e.g., teams)	☐	☐	☐	☐	☐

Directions for questions 56-93: Please select the answer that best describes your child.

	Not at all	Sometimes	Pretty Much	Very Much	All the time
56. Complains of stomach aches	☐	☐	☐	☐	☐
57. Pouts and sulks	☐	☐	☐	☐	☐

	Not at all	Sometimes	Pretty Much	Very Much	All the time
58. Appears happy	☐	☐	☐	☐	☐
59. Unable to make up his/her mind	☐	☐	☐	☐	☐
60. Cries often	☐	☐	☐	☐	☐
61. Moves slowly	☐	☐	☐	☐	☐
62. Complains of headache	☐	☐	☐	☐	☐
63. Demonstrates slow speech	☐	☐	☐	☐	☐
64. Spends more time with adults	☐	☐	☐	☐	☐
65. Talks a lot	☐	☐	☐	☐	☐
66. Spends time alone in room	☐	☐	☐	☐	☐
67. Carefree in spirit	☐	☐	☐	☐	☐
68. Self-critical	☐	☐	☐	☐	☐
69. Finds it difficult to leave parents	☐	☐	☐	☐	☐
70. Enjoys new situations	☐	☐	☐	☐	☐
71. Forgetful	☐	☐	☐	☐	☐
72. Easily frustrated	☐	☐	☐	☐	☐
73. Tires easily	☐	☐	☐	☐	☐
74. Gets angry	☐	☐	☐	☐	☐
75. Hostile to others	☐	☐	☐	☐	☐
76. Sullen	☐	☐	☐	☐	☐
77. Bowel problems	☐	☐	☐	☐	☐
78. Cheerful in nature	☐	☐	☐	☐	☐
79. Nausea or vomiting	☐	☐	☐	☐	☐

	Not at all	Sometimes	Pretty Much	Very Much	All the time
80. Temper outbursts	☐	☐	☐	☐	☐
81. Neat appearance	☐	☐	☐	☐	☐
82. Suicidal thoughts	☐	☐	☐	☐	☐
83. Eats poorly	☐	☐	☐	☐	☐
84. Falls asleep well	☐	☐	☐	☐	☐
85. Refuses to go to school	☐	☐	☐	☐	☐
86. Leaves school - "hooks"	☐	☐	☐	☐	☐
87. Moody or irritable	☐	☐	☐	☐	☐
88. Talks about fear of parents dying	☐	☐	☐	☐	☐
89. Works on tasks enthusiastically	☐	☐	☐	☐	☐
90. Sleeps through the night	☐	☐	☐	☐	☐
91. Awakens in morning earlier than necessary	☐	☐	☐	☐	☐
92. Needs help from adults	☐	☐	☐	☐	☐
93. Generally outgoing	☐	☐	☐	☐	☐

Directions for questions 94-134: Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then, for each statement, select the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	Not True or Hardly Ever True	Somewhat True or Sometimes True	Very True or Often True
94. When my child feels frightened, it is hard for him/her to breathe	☐	☐	☐
95. My child gets headaches when he/she is at school	☐	☐	☐
96. My child doesn't like to be with people he/she doesn't know well.	☐	☐	☐

	Not True or Hardly Ever True	Somewhat True or Sometimes True	Very True or Often True
97. My child gets scared if he/she sleeps away from home	☐	☐	☐
98. My child worries about other people liking him/her	☐	☐	☐
99. When my child gets frightened, he/she feels like passing out	☐	☐	☐
100. My child is nervous	☐	☐	☐
101. My child follows me wherever I go	☐	☐	☐
102. People tell me that my child looks nervous	☐	☐	☐
103. My child feels nervous with people he/she doesn't know well	☐	☐	☐
104. My child gets stomach aches at school	☐	☐	☐
105. When my child gets frightened, he/she feels like he/she is going crazy	☐	☐	☐
106. My child worries about sleeping alone	☐	☐	☐
107. My child worries about being as good as other kids	☐	☐	☐
108. When my child gets frightened, he/she feels like things are not real	☐	☐	☐
109. My child has nightmares about something bad happening to his/her parents	☐	☐	☐
110. My child worries about going to school	☐	☐	☐
111. When my child gets frightened, his/her heart beats fast	☐	☐	☐
112. My child gets shaky	☐	☐	☐
113. My child has nightmares about something bad happening to him/her	☐	☐	☐
114. My child worries about things working out for him/her	☐	☐	☐
115. When my child gets frightened, he/she sweats a lot	☐	☐	☐
116. My child is a worrier	☐	☐	☐
117. My child gets really frightened for no reason at all	☐	☐	☐
118. My child is afraid to be alone in the house	☐	☐	☐

	Not True or Hardly Ever True	Somewhat True or Sometimes True	Very True or Often True
119. It is hard for my child to talk with people he/she doesn't know well	☐	☐	☐
120. When my child gets frightened, he/she feels like he/she is choking	☐	☐	☐
121. People tell me that my child worries too much	☐	☐	☐
122. My child doesn't like to be away from his/her family	☐	☐	☐
123. My child is afraid of having anxiety (or panic) attacks	☐	☐	☐
124. My child worries that something bad might happen to his/her parents	☐	☐	☐
125. My child feels shy with people he/she doesn't know well	☐	☐	☐
126. My child worries about what is going to happen in the future	☐	☐	☐
127. When my child gets frightened, he/she feels like throwing up	☐	☐	☐
128. My child worries about how well he/she does things	☐	☐	☐
129. My child is scared to go to school	☐	☐	☐
130. My child worries about things that have already happened	☐	☐	☐
131. When my child gets frightened, he/she feels dizzy	☐	☐	☐
132. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (e.g., read aloud, speak, play a game, play a sport)	☐	☐	☐
133. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well	☐	☐	☐
134. My child is shy	☐	☐	☐

Directions for questions 135-146: Please select "yes" or "no" for each question.

	Yes	No
135. Does your child have thoughts or obsessions about which they can't stop thinking? Obsessions are thoughts, ideas, or pictures that keep coming into your child's mind even though he or she does not want them to.	☐	☐
136. Does your child have compulsions or habits which they can't stop doing? Compulsions are things that your child feels he or she has to do although he or she may know they do not make sense.	☐	☐
137. Has your child ever experienced any of the following traumatic events: natural disaster (e.g., flood, hurricane, tornado, earthquake), fire, explosion, or industrial accident; transportation accident (e.g., car accident, plane crash); physical assault (e.g., being attacked, beaten up); sexual assault (e.g., rape, attempted rape, made to perform any type of sexual act through force or threat of harm); captivity or exposure to a war-zone; life-threatening illness or injury; sudden, unexpected death of or injury to someone close to them; or serious injury, harm, or death to someone else that they witnessed or caused?	☐	☐
138. Has your child had any unusual experiences such as: hearing voices, seeing visions, having ideas they later found out were not true, mind reading, ESP, thoughts being controlled by others, or seeing things on TV that they think refer to them specifically?	☐	☐
139. Are you concerned your child has been drinking alcohol?	☐	☐
140. Are you concerned your child has been using marijuana, illegal drugs, or prescription medications for non-medical reasons?	☐	☐
141. Are you concerned about your child's overall level of development?	☐	☐
142. Are you concerned about your child's development in the areas of speech and language?	☐	☐
143. Are you concerned about your child's learning development in the areas of mathematics, reading, etc.?	☐	☐
144. Has your child had problems with social interactions (e.g., eye contact, social reciprocity, making and keeping friends); social communications (e.g., delays in language, inability to initiate or sustain a conversation, echolalia); or restricted repetitive and stereotyped patterns of behavior, interests, and activities (e.g., hand or finger flapping; rigid, perseverative play)?	☐	☐
145. Has your child had any problems with enuresis (bed-wetting)?	☐	☐
146. Has your child had any problems with encopresis (fecal incontinence)?	☐	☐

Past Mental Health Services

Therapy/Treatments/Interventions

Has the child ever received any of the following therapies privately or in school? (Psychiatric treatment, Psychological treatment, Counseling, Group therapy, Family therapy, Behavioral interventions, Neurofeedback, Physical therapy, Occupational therapy, Speech & language therapy):

If yes, please elaborate, including approximate dates, provider, and reasons for going:

_____

_____

_____

_____

_____

_____

_____

Evaluations/Assessments

Has the child ever had any of the following assessments/evaluations performed privately or in school? (Learning/academic/IQ, Psychiatric, Psychological, Developmental, Physical, Neuropsychological, Occupational, Speech & language, Audiology, Neurological (e.g., MRI, CAT scan, EEG, etc.), other) IF APPLICABLE, PLEASE BRING PRIOR REPORT(S) TO YOUR APPOINTMENT

If yes, please elaborate, including approximate dates, provider, and reasons for going:

_____

_____

_____

_____

_____

_____

_____

Previous Diagnoses:

Has the child ever been given any diagnoses? If yes, please elaborate, including diagnosis and approximate date/age diagnosed:

_____

_____

_____

Please note any important additional information regarding the child's mental health treatment/evaluation history: _____

_____

_____

PSYCHIATRIC MEDICATION HISTORY

Has your child ever taken any medication for psychiatric treatment? (circle one) yes no

If YES, please fill out the table below to the best of your knowledge:

Medication name	Dose	How long?	End Date	Side Effects (if applicable)	Reason for stopping?

Notes: _____

_____

_____

_____

_____

_____

MEDICAL HISTORY

Pediatrician's/Primary Care:

Physician's name: _____ Office Name: _____

Phone number: _____ Fax number: _____

What was the date of the child's last physical exam? _____

Please list and describe any current or past medical diagnoses or conditions: _____

_____

_____

_____

Please list all of the child's current medications and previous medications that were taken for more than one month (include prescription and over-the-counter), **excluding medications for psychiatric care**:

Medication name	Dose	How long?	End Date	Side Effects (if applicable)	Reason for stopping?

Does the child follow the medication regime? (circle one) yes no

Vision:
Does the child have any vision or eye problems? (circle one) yes no

If yes, please elaborate: _____

Date of last vision screen: _____

Hearing:
Does the child have any hearing problems? (circle one) yes no

If yes, please elaborate: _____

Date of last hearing screen: _____

Allergies:
Does the child have any known allergies to medications, foods, animals, etc.? (circle one) yes no

If yes, please elaborate: _____

Symptoms if in contact: _____

Please note any important additional information regarding the child's physical health and/or medical history: _____

_____

_____

_____

MENSTRUATION AND PREGNANCY HISTORY

If the patient has not begun menstruation or this is not applicable, please skip this section.

At what age did you begin menstruation? _____

Which of these best describe your premenstrual symptoms?

☐ Dysphoria
☐ Cramps
☐ Appetite change
☐ Bloating
☐ Sleep disturbance
☐ None of these

Do you have a method of contraception? (check all that apply)

☐ No method of contraception
☐ Intrauterine (e.g., IUD)
☐ Hormonal (e.g., implant, injection, "the pill," patch, hormonal vaginal contraceptive ring)
☐ Other: _____
☐ Barrier (e.g., diaphragm, male/female condom, spermicide)
☐ Fertility Awareness-based (e.g., natural family planning)
☐ Permanent (e.g., male/female sterilization, infertility)

Have you ever been pregnant? (circle one) yes no

If YES, how many times? _____

Have you ever given birth? _____ How many times? _____

Have you had any miscarriages? _____ How many times? _____

Have you had any abortions? _____ How many times? _____

Notes: _____

_____

_____

FAMILY MENTAL HEALTH/SOCIAL HISTORY

Please note if any of the child's family members have experienced and/or been diagnosed with any of the following (check all that apply):

- ☐ Depression
- ☐ Bipolar/Manic-Depressive Disorder
- ☐ Suicide or attempt(s)
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Obsessive-Compulsive Disorder
- ☐ Tourette syndrome/Tic Disorder
- ☐ Autism/Asperger's syndrome/Pervasive Developmental Disorder (PDD)
- ☐ "Absent Minded Professor" Stereotype
- ☐ Developmental Delays/Mental Retardation
- ☐ ADHD/Attention Difficulties
- ☐ Hyperactivity (especially as a child)
- ☐ Legal Trouble/Problems or Police Contact
- ☐ Problems Keeping a Job
- ☐ Schizophrenia
- ☐ Psychosis or Thought Problems
- ☐ Learning Disabilities/Difficulties; Reading Disorder/Dyslexia
- ☐ Kept Back in School
- ☐ Special Education
- ☐ Speech Problems (especially as a child)
- ☐ Bedwetting/Bowel Movement Withholding
- ☐ Aggressive or Violent Behaviors
- ☐ Erratic Temper; Moods Quickly Change
- ☐ Physical or Sexual Abuse
- ☐ Alcohol Abuse/Dependence
- ☐ Other Substance Abuse/Dependence
- ☐ Outpatient Psychotherapy
- ☐ Inpatient Psychiatric Treatment
- ☐ Other: _____

If so, who, and how has it impacted the child? Is this an ongoing issue? Is this relative biologically related to the child?

_____

_____

_____

_____

_____

Please note any important additional information regarding family mental health and/or social history:

_____

_____

_____

FAMILY MEDICAL HISTORY

Please note if any of the child's family members have experienced and/or been diagnosed with any of the following (check all that apply):

- ☐ Birth defects
- ☐ Blood problems
- ☐ Brain disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Eating disorders
- ☐ Gastrointestinal problems
- ☐ Hearing problems
- ☐ Heart rhythm problems
- ☐ Hospitalizations
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Movement problems (e.g., slowness in walking)
- ☐ Neurofibromatosis
- ☐ Neurological disorder/problems
- ☐ Other heart problems
- ☐ Parkinsons
- ☐ Seizures
- ☐ Speech problems (e.g., slowness in talking)
- ☐ Sudden cardiac death (for persons under 60 years of age)
- ☐ Sudden unexplained death (for persons under 60 years of age)
- ☐ Thyroid disease
- ☐ Visual problems
- ☐ Other: _____

If so, who, and how has it impacted the child? Is this an ongoing issue? Is this relative biologically related to the child?

_____

_____

_____

_____

_____

Please note any important additional information regarding family medical history:

_____

_____

_____

_____

_____

_____

PRENATAL DEVELOPMENT AND BIRTH HISTORY

Please select all that apply to the child's prenatal development:

- ☐ The mother had prenatal care while pregnant with the child
- ☐ The child was conceived through in vitro fertilization
- ☐ The mother received medicines to increase fertility
- ☐ The child was a multiple birth, if so what order was the child born (e.g. first, second, etc): ____
- ☐ The mother had previous pregnancies, if so how many: _____
- ☐ Abnormal findings in ultrasound, if so please explain below

Did the mother have any complications while pregnant with the child? (circle one) yes no

If yes, please explain: _____

_____

_____

Please list any medications prescribed to the mother during pregnancy: _____

_____

Did the mother use any of the following while pregnant? (please check all that apply):

- ☐ Caffeine
- ☐ Tobacco/Nicotine
- ☐ Alcohol
- ☐ Recreational drugs
- ☐ Prescription medication/medical treatment other than routine prenatal care
- ☐ Other: _____

Please describe the items selected above (including types and frequency of usage): _____

_____

If the mother had any dietary restrictions while pregnant, please describe: _____

_____

Parents' ages at time of delivery: Parent 1: _____ Parent 2: _____

How long was labor (i.e., how many hours from first contractions to birth)? Please only list the number of hours (for example, "8"): _____

Was the mother under anesthesia during delivery? ☐ No ☐ Yes, Local ☐ Yes, Spinal ☐ Yes, General

Was the child born: ☐ On Time ☐ Early, how many days: ____ ☐ Late, how many days: ____

How much did the baby weigh at the time of delivery? (Please enter weight in pounds and ounces) _____

Was the baby normally active? (circle one) yes no

What were the baby's Apgar scores? 1 min _____ 5 min _____

Please check off any of the following items that pertained to the child during delivery and post delivery:

- ☐ Abnormal color
- ☐ Baby did not cry right away
- ☐ Birth defect
- ☐ Breeched
- ☐ Cesarean
- ☐ Cord around neck
- ☐ Difficulty breathing
- ☐ Fetal distress
- ☐ Induced
- ☐ Natural childbirth
- ☐ Jaundice
- ☐ Needed a respirator
- ☐ Received oxygen
- ☐ Received phototherapy
- ☐ Received transfusions
- ☐ Seizure
- ☐ Use of forceps
- ☐ Other: _____

Please describe any additional complications: _____

_____

Where was the baby born? ☐ Hospital ☐ Home ☐ Other: _____

If the baby was born in a hospital, how many days was the baby in the hospital after delivery? _____

If the baby was born in a hospital, did mother and baby leave the hospital together? ☐ Yes ☐ No

After birth, did the baby stay in:
☐ N/A ☐ Well-baby Nursery ☐ Neonatal Intensive Care Unit (NICU) ☐ Other:
_____

Please describe any medical problems the child had in the first few days/weeks of life: _____

_____

Did either parent have significant problems adjusting after the birth (including if the mother had problems with depression)? ☐ Yes ☐ No if yes, please explain:

_____

_____

Adoption:

Was the child adopted? ☐ Yes ☐ No

If yes, please answer the following:

How old was the child when placed in the adopted parents' care? _____

Adoption Agency Name : _____

Country of Adoption if Applicable: _____

Please briefly describe the pre-adoption environment (open or closed adoption):

_____

_____

_____

Please briefly describe the circumstances of the adoption:

_____

_____

_____

If you have biological children in addition, explain adoption circumstance:

_____

_____

Please note any important additional information regarding the child's prenatal development or birth history:

_____

_____

_____

DEVELOPMENTAL HISTORY

Please check off any of the following items that describe the child in infancy, toddlerhood, and/or preschool:

- ☐ Active baby
- ☐ Anemia
- ☐ Asthma
- ☐ Bad foot odor
- ☐ Bed wetting
- ☐ Chronic sniffles
- ☐ Constipation
- ☐ Convulsions
- ☐ Cradle cap
- ☐ Defiant
- ☐ Diaper rash
- ☐ Diarrhea
- ☐ Did not enjoy cuddling
- ☐ Difficult to soothe
- ☐ Difficulty chewing
- ☐ Difficulty sleeping
- ☐ Difficulty sucking
- ☐ Disconnected socially
- ☐ Eczema or psoriasis
- ☐ Excessive tantrums
- ☐ Excessively irritable
- ☐ Excessively restless
- ☐ Failure to thrive
- ☐ Fears/phobias
- ☐ Finicky eating
- ☐ Growing pains
- ☐ Hyperactivity
- ☐ Jaundice
- ☐ Limp
- ☐ Nightmares
- ☐ Not calmed by being held; Difficult to comfort
- ☐ Poor muscle control
- ☐ Poor muscle tone
- ☐ Poor teeth
- ☐ Poor weight gain
- ☐ Sensory issues
- ☐ Stiff
- ☐ Stomachaches
- ☐ Tremors
- ☐ Under responsive
- ☐ Very sweaty
- ☐ Warts
- ☐ Other: _____

Was the baby (check all that apply): ☐ Colicky ☐ Breast fed ☐ Bottle fed ☐ On a special diet

If yes to any item above, please describe and specify how long for each: _____

_____

_____

Please describe any other feeding issues (e.g., sensitivities; textures; reflux; resistance; difficulty swallowing; drooling, etc.): _____

_____

Was the child an "easy baby" who did not cry easily and was flexible?

☐ Yes, very much so ☐ Yes, pretty easy ☐ Probably about average ☐ No, pretty difficult ☐ No, extremely difficult

When the child was a baby, how was s/he with other people?

☐ Above average ☐ Very wary of strangers, very upset if held by or left with others

☐ Indifferent to strangers, no reaction if held by or left with others

Was the child an active infant/toddler?

☐ Low energy, usually quiet and inactive ☐ Not very active ☐ About average ☐ Quite active

☐ Extremely restless and active, into everything

As an infant/toddler, how insistent was the child when s/he wanted something?

☐ Not insistent at all ☐ Not very insistent ☐ About average ☐ Somewhat insistent ☐ Very insistent

Please note when the following milestones were achieved:

Motor Development:

	Age - years/months	**Timing** **(early, normal, late, not yet achieved)**
Rolled over		
Sat without support		
Grasped pencil/crayon		
Scribbled with a crayon		
Crawled		
Stood up		
Walked holding on		
Walked without holding on		
Fed self		
Drank from a cup		
Dressed self		
Tied shoes		
Pedaled tricycle		
Rode bike		
Swam		

Please select the child's MOST RECENT height and weight percentiles:

Height:
☐ Don't Know ☐ Below 3rd percentile ☐ 3rd-10th percentile ☐ 11th-24th percentile ☐ 25th-75th percentile
☐ Above 75th percentile

Weight:
☐ Don't Know ☐ Below 3rd percentile ☐ 3rd-10th percentile ☐ 11th-24th percentile ☐ 25th-75th percentile
☐ Above 75th percentile

What was the child's age (in years) when these percentiles were measured? _____

Have you or the child's pediatrician ever been concerned about the child's rate of growth, height, or weight? (circle one) yes no
If yes, please explain: _____

Language Development:

	Age - years/months	Timing (early, normal, late, not yet achieved)
Babbled		
Spoke single words		
Spoke two word phrases		
Spoke in short sentence		
Responded to another person's smile by smiling back		
Communicated wants by pointing, gesturing, etc.		
Imitated others' behavior		
Identified words that rhyme		
Started to read		
Differentiated left from right		
Followed commands		
Easily understood by others (not family members)		

If there have been no concerns, please skip to the Sensorimotor Development section.

Please check off the following items that relate to the child's language (check all that apply):

- ☐ Avoids being read to
- ☐ Does not enjoy listening to stories
- ☐ Gets frustrated when explaining things orally
- ☐ Has a hard time asking for help or making his/her wants and needs known to others
- ☐ Has a hard time expressing his/her ideas
- ☐ Leaves off endings (e.g., plurals, -ed) when speaking in sentences
- ☐ Leaves off small words (e.g., the, is, to) when speaking in sentences
- ☐ Mispronounces words or leaves off sounds in words
- ☐ Names things incorrectly
- ☐ Often asks others to repeat what they have said
- ☐ Repeats sounds, words, or phrases over and over
- ☐ Talks around an issue without coming to the point
- ☐ Trouble finding words s/he wants to use
- ☐ Unable to follow one step directions
- ☐ Unable to follow multi-step directions
- ☐ Unable to remember short messages
- ☐ Unable to respond correctly to who/what/where/when/why questions
- ☐ Unable to respond correctly to yes/no questions
- ☐ Unable to understand what people are saying
- ☐ Other: _____

Is the child's speech (check all that apply):

☐ Usually soft
☐ Usually loud
☐ Hoarse, breathy, or strained-sounding
☐ Dysfluent (e.g., stuttering)
☐ Filled with "um" and "you know"
☐ Unable to be understood by familiar others
☐ Unable to be understood by unfamiliar others

The child currently communicates using (check all that apply):

☐ Body language
☐ Sounds (e.g., vowels and vocalizations)
☐ Single words
☐ 2 to 4 word sentences
☐ Full sentences
☐ Other: _____

Was the child ever recommended to have speech or language therapy? (circle one) yes no

Has the child ever had speech or language therapy? (circle one) yes no

If the child has had speech or language therapy, please specify where and when. If possible, please give any information related to goals at that time or currently. _____
_____
_____

Was the child ever recommended to have occupational therapy (OT)? (circle one) yes no

Has the child ever had occupational therapy (OT)? (circle one) yes no

If the child has had occupational therapy (OT), please specify where and when. If possible, please give any information related to goals at that time or currently. _____
_____
_____

Sensorimotor Development
If there have been no concerns (if no concerns, please skip to Toileting section)

Please check off the following items that relate to the child's sensory and motor skills (check all that apply):

TACTILE (TOUCH):

☐ Has trouble managing personal/physical space
☐ Over sensitive to clothing/textures/foods
☐ Under sensitive to clothing/textures/foods

VISUAL:

☐ Avoids eye contact with others
☐ Did not pass most recent vision screening
☐ Has trouble copying words from the board
☐ Has trouble tracking objects with eyes

AUDITORY (SOUND):

☐ Did not pass most recent hearing screening
☐ Fails to listen or pay attention to what is said to him/her
☐ Has difficulty if 2 or 3 step instructions are given at once
☐ History of frequent ear infections
☐ History of PE tubes in his/her ears
☐ Sensitive to loud sounds (e.g., school bells, sirens)
☐ Talks excessively/doesn't wait for his/her turn

TASTE & SMELL:

☐ Has trouble eating different textured foods
☐ Insensitive to noxious smells/tastes
☐ Picky eater
☐ Prefers spicy, sour, or bitter food flavors
☐ Sensitive to noxious smells/tastes

VESTIBULAR (MOVEMENT):

☐ Gets carsick easily
☐ Likes rough housing, jumping, crashing games
☐ Loses balance easily
☐ Prefers to be sedentary (on computer/TV) rather than play outside

MUSCLE TONE:

☐ Gets tired easily playing or writing ☐ Seems generally weak compared to other kids
☐ Slouches when sitting on floor/chair

COORDINATION:

☐ Bumps into furniture/people often
☐ Cannot ride a bike
☐ Cannot tie shoelaces
☐ Does not enjoy sports
☐ Has an excessive number of accidents compared to other children
☐ Has difficulty holding a pencil or crayon in a 3-point position
☐ Poor handwriting
☐ Has difficulty playing on playground equipment
☐ Has trouble using both hands together easily (e.g., opening milk carton, water bottle, etc.)
☐ Poor ball skills for P.E.-type activities
☐ Seems clumsy/awkward
☐ Has difficulty with sequential tasks (e.g., dressing, buttoning)

Is the child: ☐ Right handed ☐ Left handed ☐ Mixed handed/ambidextrous

Is the child currently physically athletic or coordinated?
☐ No, poorly coordinated and not naturally good at most sports ☐ About average
☐ Yes, very coordinated and naturally athletic

Does the child currently have good fine motor coordination?
☐ No, poorly coordinated in fine motor activities ☐ About average
☐ Yes, very good with fine motor activities

Toileting:

	Age - years/months	Timing (early, normal, late, not yet achieved)
Trained for urine		
Trained for bowels		

Please check off any of the following difficulties related to the child's toilet training:

☐ Bed wetting after training
☐ Nighttime soiling after training
☐ Soiling accidents during the day
☐ Urine accidents during the day

Please describe any of these difficulties, including frequency: _____

_____

Comprehension and Understanding

Does the child understand directions and situations as well as other children his/her age? ☐ Yes ☐ No

If no, please explain: _____

If the child tells a story about a show, event, etc., do you or others have difficulty understanding him/her?

☐ Yes ☐ No

If yes, is it because s/he (check all that apply):

☐ Has trouble finding the right words
☐ Is confused
☐ Is disorganized
☐ Leaves out important information
☐ Loses train of thought
☐ Other, please describe: _____

Does the child (check all that apply):

☐ Have trouble remembering things s/he really cares about?
☐ Have difficulty following routines (bedtime, dressing, etc.)?
☐ Frequently lose things or have trouble being organized?

If yes to any of the above, please describe: _____

_____

How would you rate the child's overall level of intelligence compared to other children?

☐ Below Average ☐ Average ☐ Above Average

Do you have any comments about the child's (check all that apply):

☐ Sexual knowledge or awareness ☐ Gender identity ☐ Sexual orientation

If yes to any of the above, please describe:

Environmental Exposures

Has the child ever lived near a refinery, polluted area, or in a home with lead paint? ☐ Yes ☐ No

If yes, please describe: _____

Has the child ever lived in a house that had new carpeting, paint, cabinets, or any other refurbishing that seemed to affect the child's health? ☐ Yes ☐ No

Does the child seem particularly sensitive to perfumes, gasoline, or other vapors? ☐ Yes ☐ No

What year was the child's home/apartment built? (if you don't know, skip to the next question) _____

Does the child live in a home with vinyl blinds? ☐ Yes ☐ No

If yes, what year were they put in? (if you don't know, skip to the next question) _____

Where does the child's home get water?

☐ City
☐ Well
☐ Don't know
☐ Other, please describe: _____

Primary type of heat in the child's home:

☐ Gas
☐ Electric
☐ Heating Oil
☐ Well
☐ Wood Stove
☐ Don't know
☐ Other, please describe: _____

Does the child (check all that apply):

☐ live in a home around where pesticides, herbicides, or other chemicals are sprayed
☐ live a home with a water purification system
☐ live in a home with an air purifier
☐ live near a refinery
☐ live near the woods
☐ live near an industrial area
☐ live near the water

If the child lives near water, what type of water is it?

☐ River
☐ Ocean
☐ Swamp
☐ Lake
☐ Other: _____

Describe the child's bedroom (curtains, blinds, carpet, feather pillows, etc.): _____

_____

_____

Describe the flooring in other rooms the child spends time in at home: _____

_____

Please note any important additional information regarding the child's developmental history: _____

_____

_____

CURRENT LIVING SITUATION

How many people currently live in the child's household? (NOT including the child) _____

If child lives in more than one household, please specify:

Name	Person's relationship to the child	If the person is a family member, is he/she biological, step, adopted, etc.	Gender	Age	Grade/Job

Please provide the following information about the child's biological parents:

Parent 1

Name: _____ Living or Deceased? _____ Biological? y/n_____

Age (current or when deceased): _____ Birthplace: _____

Occupation (current or previous): _____

Number of hours away from home per day. If not living in the home, leave blank._____

Parent 2

Name: _____ Living or Deceased? _____ Biological? y/n_____

Age (current or when deceased): _____ Birthplace: _____

Occupation (current or previous): _____

Number of hours away from home per day. If not living in the home, leave blank._____

What languages are spoken at home? If more than one, please indicate which language is primary within the home. _____

Please note any important additional information regarding the child's current living situation: _____

_____

_____

FAMILY RELATIONSHIPS

Parental Relationships/Parenting

Are the child's parents currently:

☐ Together, but not living together or married ☐ Separated
☐ Living together ☐ Divorced
☐ Married ☐ Other, please describe: _____

This has been the situation for the child's family/parents for how long? _____

If the child's parents are married, describe the current relationship, including any significant marital conflicts: _____

_____

If the child's parents are separated or divorced, has "parent 1" remarried? ☐ Yes ☐ No
If yes, for how long has "parent 1" been remarried? _____

If the child's parents are separated or divorced, has "parent 2" remarried? ☐ Yes ☐ No
If yes, for how long has "parent 2" been remarried? _____

Please list any previous parental marriages/long-term relationships involving the child's parents: _____

_____

If the child's parents are separated or divorced, is their relationship (check all that apply):

☐ No contact ☐ Conflictual
☐ Minimal communication ☐ High conflict (violence, no-contact order, etc.)
☐ Amicable ☐ Other, please describe: _____

If the child's parents are separated or divorced, what are the current custody and visitation arrangements? _____

_____

_____

Who is the child's primary caregiver? _____

Who cares for the child when the primary caregiver is away? _____

What are the current care arrangements for the child before and after school? _____

Who usually disciplines the child? _____

To what extent do the child's parents agree on parenting issues and discipline (if applicable)?
☐ Never Agree ☐ Rarely Agree ☐ Sometimes Agree ☐ Usually Agree ☐ Always Agree

Which of the following methods of discipline are used with the child (check all that apply):

	How effective is the method (usually): (Effective/ Ineffective/ Makes it Worse/ Varies)
Loss of privileges	
Grounded from peers	
Grounded from TV and/or computer	
Made to do extra chore(s)	
Spanking or other physical punishment	
Time out	
Reward chart	
Token economy	
Contingency management	
Other:	

Please explain how the child tends to respond to discipline: _____

_____

Child's Relationships in the Family

Describe the child's relationship with his/her parents, noting if there is conflict and/or if the child has difficulty separating from the parent(s): _____

_____

_____

Describe the child's relationship with his/her siblings, noting if there is conflict: _____

_____

_____

Please check off the activities in which the child participates with the family (check all that apply):

- ☐ Movies
- ☐ Meals
- ☐ Conversations
- ☐ Visits with relatives
- ☐ Sports
- ☐ Television
- ☐ Religious/spiritual activities
- ☐ Games
- ☐ Trips
- ☐ Other, please describe: _____

Please note any important additional information regarding the child's family relationships: _____

_____

_____

EDUCATIONAL HISTORY

How old was the child when s/he first attended school? _____

Were there any problems when the child first started school? ☐ Yes ☐ No
If yes, please explain: _____

Did the child (check all that apply):
☐ Receive early intervention services or attend Head Start ☐ Attend day care and/or preschool
☐ Attend kindergarten

If yes to any of the above, please describe, including any problems and approximately how many hours per week (if applicable): _____
_____

In the table below, please list all schools that the child has attended (NOT including the current school):

School Name	Grade(s)	Year(s)

Name of the child's current school: _____ Grade: _____

What year did the child start this school? _____ School Phone Number: _____

School address: _____

School email: _____ School Fax: _____

Is this a: ☐ Public School ☐ Private School ☐ Other: _____

In the next table, please indicate the child's academic performance per year in school:

	Failing	Below Average	Average	Above Average	Superior
Preschool	☐	☐	☐	☐	☐
Kindergarten	☐	☐	☐	☐	☐
Grade 1	☐	☐	☐	☐	☐
Grade 2	☐	☐	☐	☐	☐
Grade 3	☐	☐	☐	☐	☐
Grade 4	☐	☐	☐	☐	☐
Grade 5	☐	☐	☐	☐	☐
Grade 6	☐	☐	☐	☐	☐
Grade 7	☐	☐	☐	☐	☐
Grade 8	☐	☐	☐	☐	☐
Grade 9	☐	☐	☐	☐	☐
Grade 10	☐	☐	☐	☐	☐
Grade 11	☐	☐	☐	☐	☐
Grade 12	☐	☐	☐	☐	☐

Please describe any significant changes in the child's school performance over the years: _____

_____

_____

What are the child's current grades or GPA (if applicable)? _____

If there are poor grades, what do you see as the cause:_____

Has the child had any education-related testing or assessment? ☐ Yes ☐ No

If yes, what tests and what were the results? _____

_____

Does the child have any known learning disabilities? ☐ Yes ☐ No

If yes, please describe: _____

_____

Has the child ever (check all that apply):

☐ Received support/services from the school ☐ Received private support/special services

☐ Been on an IEP or 504 plan ☐ Participated in a gifted and talented program in school

In the next table, please indicate the child's behavioral performance per year in school:

	Poor	Fair	Good	Excellent
Preschool	☐	☐	☐	☐
Kindergarten	☐	☐	☐	☐
Grade 1	☐	☐	☐	☐
Grade 2	☐	☐	☐	☐
Grade 3	☐	☐	☐	☐
Grade 4	☐	☐	☐	☐
Grade 5	☐	☐	☐	☐
Grade 6	☐	☐	☐	☐
Grade 7	☐	☐	☐	☐
Grade 8	☐	☐	☐	☐
Grade 9	☐	☐	☐	☐
Grade 10	☐	☐	☐	☐
Grade 11	☐	☐	☐	☐
Grade 12	☐	☐	☐	☐

If yes to any of the above, please describe (including age of the child, the reasons, and any notable changes): _____

_____

Has the child ever (check all that apply):

☐ Had frequent school absences or missed an extended amount of school ☐ Repeated a grade

☐ Been suspended ☐ Refused to go to school

If yes to any of the above, please provide details: _____

_____

Does the child like school? ☐ Yes ☐ No

Please describe the child's attitude towards school: _____

_____

What are the child's MOST favorite subjects, sports, and/or activities? What does s/he excel at? _____

_____

What are the child's LEAST favorite subjects, sports, and/or activities? What does s/he have the most difficulty with? _____

_____

Please check any of the following that describe the child at school (check all that apply):

- ☐ Considered "bright but unmotivated"
- ☐ Daydreams
- ☐ Difficulties with peers
- ☐ Difficulty being quiet
- ☐ Difficulty following instructions
- ☐ Difficulty getting started on tasks
- ☐ Difficulty in groups
- ☐ Difficulty keeping hands to self
- ☐ Difficulty sitting still
- ☐ Difficulty staying focused during independent work
- ☐ Difficulty transitioning to a new task
- ☐ Distractibility
- ☐ Does not complete classroom work
- ☐ Does not do homework
- ☐ Does not remain seated
- ☐ Does not speak to peers at school
- ☐ Does not speak to teachers at school
- ☐ Excessive time to complete assignments
- ☐ Fails to check homework
- ☐ Frequently sent out of class
- ☐ Has a pattern of highly variable grades
- ☐ Has achieved less academically than parents or siblings (for age)
- ☐ Hyperactivity
- ☐ Impulsive
- ☐ Interferes with others' tasks
- ☐ Makes careless mistakes
- ☐ Meltdowns or tantrums
- ☐ Messy and disorganized
- ☐ Noncompliant in class
- ☐ Not wanting to go to school
- ☐ Oppositional with teachers
- ☐ Poor at math
- ☐ Poor at spelling
- ☐ Poor attention
- ☐ Poor handwriting
- ☐ Poor reader
- ☐ Requires additional supervision
- ☐ Skips school
- ☐ Talks inappropriately
- ☐ Test anxiety
- ☐ Too withdrawn or passive
- ☐ Upset when leaving parents
- ☐ Works too quickly
- ☐ Works too slowly
- ☐ Written language difficulties

Please note any important additional information regarding the child's educational history: _____

_____

_____

_____

_____

SOCIAL HISTORY

Please describe the child's overall current social skills and peer relationships:

_____

_____

_____

Please describe how you think the child interacts with peers while at school:

_____

_____

_____

Would you describe the child's social support as:

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Are you satisfied with the child's social situation? ☐ Yes ☐ No

Is the child satisfied with his/her social situation? ☐ Yes ☐ No

Does the child (check all that apply):

☐ have a best friend or friends
☐ have difficulty initiating activities with peers
☐ get into frequent conflicts/fights with peers
☐ have difficulty making friends
☐ have difficulty keeping friends
☐ have difficulty getting along with adults
☐ seem interested in having friends
☐ have friends that are a poor influence
☐ get invited to extracurricular activities (e.g., birthday parties, play dates)
☐ show an interest in getting to know other children when in a new setting (e.g., park, party)
☐ spend the night away from home

The child plays/interacts with children that are (check all that apply):

☐ The same age ☐ Younger ☐ Older

Does the child seem to miss social cues (e.g., not understanding when s/he is being teased, not understanding humor, not recognizing when children are disinterested in what s/he is talking about, perceives hostility when there is none)? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Has the child been bullied/teased? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Has the child bullied other children or been aggressive in play with others? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Please note any important additional information regarding the child's social history:

_____
_____
_____
_____
_____
_____

LIFESTYLE HEALTH

Being as descriptive as possible, please describe the child - what is he/she like? Describe his/her temperament, strengths, and interests: _____

_____

_____

_____

_____

Daily Living

Please select the best description of the child with respect to the following daily functions:	Needs a lot of help	Needs some help	Needs no help
Getting dressed	☐	☐	☐
Eating	☐	☐	☐
Bathing	☐	☐	☐
Getting food, etc.	☐	☐	☐
Chores/cleaning	☐	☐	☐

Sleep

What is the child's overall level of sleep quality?

☐ Poor ☐ Fair ☐ Good ☐ Excellent

How many hours of sleep does the child get during a typical night? _____

What time does the child usually go to sleep? _____

What time does the child usually wake up? _____

Does the child have standard bedtime routines or rituals? ☐ Yes ☐ No

If yes, please describe: _____

_____

Does the child sleep in the parents' room:

☐ Not at All ☐ Some of the Night ☐ All of the Night

If the child sleeps in the parents' room, please rate how concerned you are about this:

☐ Not at All ☐ Mildly ☐ Moderately ☐ Extremely

Please check off the following items that relate to the child's sleep:

☐ Bed wetting
☐ Bedtime behavior problems
☐ Nighttime cough frequently
☐ Restless sleeping

☐ Can't sleep alone
☐ Chronic "night owl"
☐ Chronically tired from inadequate sleep
☐ Difficulty falling asleep
☐ Difficulty staying asleep
☐ Frequent wakening
☐ Grinds teeth
☐ Naps during the day
☐ Nightmares
☐ Sleep apnea
☐ Sleep walking
☐ Snoring
☐ Takes medicine in order to sleep
☐ Very heavy sleeper
☐ Very light sleeper
☐ Waking too early
☐ Other sleeping issues: _____

Describe any past or present concerns/difficulties regarding the child's sleep patterns:

_____

_____

Nutrition/Eating

Please indicate if the child has had recent significant weight change:

☐ Weight Loss ☐ Weight Gain ☐ Neither Weight Loss nor Weight Gain

If there was a recent significant weight change (loss or gain), how many pounds? _____

Describe the child's appetite and diet:

_____

_____

Please check off the following items that relate to the child's diet/eating (check all that apply):

☐ Mostly baby foods
☐ Mostly meat
☐ Mostly carbohydrates (bread, pasta, etc.)
☐ Mostly vegetarian
☐ Mostly dairy (cheese, milk, yogurt)
☐ Eats too little
☐ Eats too much
☐ Excessively picky eater
☐ Strong aversion to eating textured foods
☐ Takes very long time to eat meals
☐ Takes medicine in order to sleep
☐ Other diet/eating issues:
_____

Does the child have any food sensitivities/allergies? ☐ Yes ☐ No

If yes, please describe: _____

_____

Has the child tried any dietary modifications? ☐ Yes ☐ No

If yes, please describe: _____

_____

Please describe the child's stool pattern, frequency, and consistency (e.g., daily, foul, large, mushy, brown): _____

Extracurricular Activities:

Please describe how the child generally spends her/his free time (e.g., plays alone, plays with friends, plays sports, watches TV, plays video games): _____

_____

_____

What extracurricular activities, sports, and/or other special interests does the child engage in (inside or outside of school)? Also, please describe how well you feel the child does in these areas: _____

_____

_____

Please list any additional organizations, clubs, teams, or groups in which the child participates: _____

_____

_____

Does the child get regular exercise? ☐ Yes ☐ No

Please describe: _____

_____

Please list the approximate number of hours per day that the child:

_____ Watches TV

_____ Plays video games

_____ Is on the computer

_____ Is outdoors

Please note any important additional information regarding the child's lifestyle health:

_____

_____

_____

_____

Substances

To your knowledge, has the child ever used any of the following (check all that apply):	Never	In the Past (Suspected)	In the Past (Confirmed)	Current (Suspected)	Current (Confirmed)
Caffeine (frequent use only; in any form - including cola drinks)					
Tobacco (in any form)					
Alcohol					
Prescription medication(s) to get high					
Recreational drug(s) (including marijuana)					
Other:					

If yes to any, please list types and briefly describe the child's use of each (including frequency/amount):

_____

_____

_____

_____

LEGAL HISTORY

Has the child ever had any police contact or legal problems? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

_____

TRAUMA HISTORY

Please indicate if the child has experienced any of the following significant events (check all that apply):	Date when this occurred	Age of child when this first occurred
Physical or emotional separations from caregivers		
Divorce of caregivers		
Death of family member(s) or other significant person(s)		
Physical trauma/abuse		
Sexual trauma/abuse		
Emotional trauma/abuse		
Neglect		
Exposure to violence, drugs, or sexually explicit material		
A significant move or moves		
An accident		
Illness or injury		
Accident, illness, or injury of family member(s) or other significant person(s)		
Family financial difficulties or job loss		
Other significant stressors in the family environment (including marital stressors)		
Other:		

If yes to any of the above, please briefly describe: _____

_____

_____

_____

How does the child handle stress? _____

_____

_____

Please note any important additional information regarding trauma/stressors in the child's life:

_____

_____

_____

RISK ASSESSMENT

To your knowledge, has the child ever reported any of the following (check all that apply):	Never	Current	In the Past
Severe feelings of hopelessness	☐	☐	☐
Suicidal ideation; Wish to not be alive or to end distress	☐	☐	☐
Thoughts of harming self	☐	☐	☐
Self-injurious behavior(s); Action(s) to harm self (e.g., cutting, mutilation)	☐	☐	☐
Suicidal action(s)/attempt(s) WITHOUT intent to die	☐	☐	☐
Suicidal action(s)/attempt(s) WITH intent to die	☐	☐	☐
Access to lethal means	☐	☐	☐
Family history of suicide	☐	☐	☐
Wish to seriously harm others	☐	☐	☐
Homicidal/violent intent(s) or action(s)	☐	☐	☐
Family violence	☐	☐	☐
Abuse/neglect	☐	☐	☐
Alcohol use	☐	☐	☐
Substance use	☐	☐	☐
Impulsivity	☐	☐	☐
Other:	☐	☐	☐

Additional Notes:

_____

_____

_____

_____

_____

_____

SPIRITUAL ORIENTATION

Please describe the spiritual orientation or religion of the child's family: _____

How active are spiritual beliefs/religion in the family's life?

☐ Not at all active ☐ Somewhat active ☐ Very active