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# CHILD PATIENT INTAKE FORM

(Please Print Clearly)

| **FAMILY INFORMATION:** List all family and household members | | | | |
|---|---|---|---|---|
| Name | Relationship | Age | Occupation/Grade | Residing w/you |
| | | | | ❍ Yes ❍ No |
| | | | | ❍ Yes ❍ No |
| | | | | ❍ Yes ❍ No |
| | | | | ❍ Yes ❍ No |
| | | | | ❍ Yes ❍ No |
| | | | | ❍ Yes ❍ No |
| | | | | ❍ Yes ❍ No |

| **PARENTS MARITAL/RELATIONSHIP HISTORY:** List all marital or partner relationships including present: | | | |
|---|---|---|---|
| Name of Spouse/Partner | Date Married | Terminated by | Date |
| | | ❍ Divorce ❍ Death ❍ Separation | |
| | | ❍ Divorce ❍ Death ❍ Separation | |
| | | ❍ Divorce ❍ Death ❍ Separation | |
| | | ❍ Divorce ❍ Death ❍ 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 | | | | |

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| | |
|---|---|
| **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?** ❍ Yes ❍ No If yes, please explain: | |
| | |
| | |
| **The child spends most of his/her time:** ❍ Alone ❍ with younger children ❍ with children same age ❍ with adults | |
| **What are the child's major interests or hobbies?** | |
| | |
| | |
| **Do you feel your child is having difficulties at home?** ❍ 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 difficultites?** ❍ Yes ❍ No | |
| If yes, please explain: | |
| | |

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## 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**

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| | | | |
|---|---|---|---|
| **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 youor child and explain below:** | | | |
| ❍ Eating | ❍ Sleeping | ❍ Nail biting | ❍ Toilet accidents |
| ❍ Over active | ❍ Nightmares | ❍ Thumb sucking | ❍ Dressing, bathing |
| ❍ Temper tantrums | ❍ Daydreaming | ❍ Unusual fears | ❍ 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:** | |

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| |
|---|
| **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** |