Child Intake Form

Name of Child: _____

Date of Birth: _____ Date Form was Completed: _____

Interviewer: _____ Grade: _____

Person Interviewed: _____ Relationship to Child: _____

1. Concerns or Reasons for Referral: - _____

2. Family History

In whose home does the child live? Natural parent/s _____ Adoptive parent/s _____ Foster parent/s _____ Other: _____

Since birth, how many homes has you child lived in? _____

Name of Mother: _____

Highest level of education (optional): _____ Occupation: _____

Does the mother live at home? _____

Amount and type of contact with child: _____

Name of Father: _____

Highest level of education (optional): _____ Occupation: _____

Does the father live at home? _____

Amount and type of contact with child: _____

List child's brothers and sisters

Name	Age	Living at home?	Grade in School or Occupation

List others living in the home and relationship to child: _____

_____

_____

What activities does the family do together? _____

_____

_____

What is the primary language spoken in the home? _____
Ethnicity of child? _____
Family Medical History? _____

_____

3. Pregnancy and Birth History

Was pregnancy planned? _____
Mother's health during pregnancy? _____
List illnesses/complications, if any? _____

_____

Medications taken during pregnancy and for what: _____

_____

Length of pregnancy (months): _____ Labor (hours): _____

Any drug use by mother (Optional)? _____ By father? _____
Alcohol use by mothers (optional)? _____ By father? _____
Smoking by mother (Optional)? _____ By father? _____

Type of Delivery: Vaginal: _____ Caesarean: _____ Why? _____

_____

Was delivery induced? _____ Why? _____
Were forceps used? _____ Why? _____
Any complications? _____

_____

Birth Weight: _____ Condition at birth: _____
Incubated? _____ Respirator? _____
Why? _____
Jaundiced? _____ If Yes, How treated? _____
Other complications if any? _____

_____

_____

Length of hospital stay for child: _____ Mother: _____

4. Early Development

Who was the primary caretaker during infancy? _____

Any long separations from mother? _____ Why? _____

_____

feeding or sleep problems, special diets: _____

At what age did the child:

Sit without support? _____ Crawl? _____

Stand? _____ Walk? _____

Speak first word? _____ Phrases? _____

Speak in sentences? _____ Follow 1-step instructions? _____

First dress self completely? _____ First undress self completely? _____

Describe any problems with speech:

_____

Any regressions in development? _____

At what age was toilet training started? _____ Completed? _____

Does your child sleep alone in his/her own bed? _____ Own Room? _____

In child right-handed or left-handed? _____

5. Medical History

Please check all the illnesses the child has had:

_____ Asthma	_____ Convulsions/Seizures	_____ Croup
_____ Ear Infection	_____ Epilepsy	_____ Headaches
_____ Chicken Pox	_____ Fever of 102 degrees	_____ Lead poisoning
_____ Measles	_____ Pneumonia	_____ Tonsillitis
_____ Mumps	_____ Loss of Consciousness	_____ Whooping Cough

Please describe any illness checked (length of illness, hospitalized, treatment, etc.):

_____

_____

_____

Allergies (please specify): _____

Tubes in ears? _____ Which ear? _____ What age? _____

Was there any concern about vision and/or hearing problems? _____

Other serious illnesses/injuries (include age): _____

_____

_____ What age? _____ For what? _____

Was child ever hospitalized? _____ _____ _____

List medications child is currently taking and for what:

6. Social Relationships

Does child make friends easily? _____
Does child have friends at school? ___ Neighborhood? ___ Organized social/sports groups? ___
Does child prefer to associate with older people? ___ Younger? _____ Same age? _____
Does child have difficulty keeping friends? _____
How does child get along with others in the family (parents/siblings)?

How is the child disciplined? _____
How does s/he play with toys? _____
When Young, was there shared play, reciprocity, shared enjoyment? _____

7. School History

Name of School (include preschool)	Grade Level	Performance at school

Describe the child's attitude and motivation for school: _____

Describe any other previous/ current school problem(s): _____

8. Additional Information

What are the child's strengths?

Areas of concern (Check all that apply)

_____ Aggressive Behavior
_____ Completion of school work
_____ Daydreaming
_____ Depression
_____ Failing grades
_____ Fears
_____ Repetitive Behaviors
_____ Special Interests
_____ Sensory
_____ Getting along with others
_____ Low self-esteem
_____ Problems understanding what he/she is told
_____ Problems expressing what he/she wants to say
_____ Temper tantrums
_____ Significant changes in behavior
_____ Hyperactivity/ Distractibility
_____ Rituals/ Rigidity
_____

Please describe any areas checked above:

Other upsetting events and/or significant losses in the life of the child or the family:

Has the child received any educational or psychological testing, therapy, or remediation?

Describe the child's morning routine:

Describe the child's evening routine:

Please life relatives (including grandparents, parents, aunts, uncles, cousins, etc.) with history of learning problems or has had contact with mental health professional or agency?

How does your child respond when stressed, frustrated, etc.?

Is there any additional information you would like to include?