

CHILD/ADOLESCENT INTAKE QUESTIONNAIRE

Information requested on this questionnaire is an important part of this child's evaluation. I appreciate your filling it out carefully and fully. Please feel free to add as much information as you want and to use the backs of pages if necessary.

The highest standards of professional confidentiality are maintained. Information about any particular individual can be released only with the explicit written consent of that person or their parent(s)/legal guardian except in exceptional legal circumstances. When consent to release information is granted, you may choose which information may/may not be released, and revoke that consent at any time.

Identifying information

Today's Date _____

Person completing this form: _____ Relationship: _____

Child's full name: _____ Name called: _____ Age: _____

Birthdate: ___/___/___ Gender: M F O Handedness: R L Height: _____ Weight: _____

Ethnicity: _____ Primary Language: _____ Other languages in the home: _____

Home address: _____

Home Phone: _____ Cell Phone(s): _____

Permission to leave phone messages: Home phone No Yes Cell phone: No Yes

Permission to email confidential information: No Yes: email address _____

Who referred you for an evaluation? _____

Has this child ever been diagnosed with a learning disability? No Yes

Has this child ever been diagnosed with Attention Deficit Disorder? No Yes

Other diagnoses & medical conditions: _____

Date of child's last psychological evaluation: _____ By whom? _____

Family Information

Parents/legal guardians: _____

With whom does the child live? _____

Frequency of contact with any biological parents not in the primary home? _____

If parents divorced, date of divorce _____

Date of mother/parent 1's remarriage, if applicable: _____

Are there step-siblings? half-siblings on mother's / P1's side? Neither

Date of father/parent 2's remarriage, if applicable: _____

Are there step-siblings? half-siblings on father's / P2's side? Neither

If child adopted (not living with either biological parent), age at time of adoption _____

6. Significant information about this child's **biological** family: Please indicate the existence of any of the following conditions in this child's **biological** family. Indicate the relationship of the person to this child (e.g., father, maternal grandmother, aunt, cousin, etc.) and describe the nature of the condition.

Reading Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who? _____	What? _____
Learning Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who? _____	What? _____
Attention Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who? _____	What? _____
Behavior Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who? _____	What? _____
Mental Health Disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who? _____	What? _____
Mental Retardation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who? _____	What? _____
Epilepsy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who? _____	What? _____
Serious Chronic Illness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who? _____	What? _____
Speech/Language Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who? _____	What? _____
Drug/Alcohol Abuse	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who? _____	What? _____
Trouble with the Law	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who? _____	What? _____

Additional comments: _____

Birth History – check here if information unknown

1. Regarding the pregnancy with this child: Any problems, complications or concerns at all? No Yes

Bleeding? No Yes: Specify _____

Illness? No Yes: Specify _____

RH Incompatibility? No Yes: Specify _____

Exposure to cigarettes? No Yes: Specify _____

Exposure to alcohol or non-prescription drugs? No Yes: Specify _____

Length of pregnancy: Early: how early? _____ On time Late: how late? _____

Medications taken? No Yes: Specify _____

Describe any other unusual circumstances, such as bedrest, or any risk factors: _____

2. Birth of this child: Any problems, complications or concerns at all? No Yes

Labor: False? No Yes Induced? No Yes Length: _____

Anesthesia? No Yes Natural? No Yes

Type of birth: Vaginal? No Yes Breech? No Yes Forceps? No Yes

Caesarean? No Yes Birthweight: _____ Apgar Score: _____

Complications: _____

Color: Normal? No Yes Blue? No Yes Jaundiced? No Yes

If jaundiced, how treated? _____

Transfusions? No Yes Incubator required? No Yes: How long: _____

Breathing Problems? No Yes Oxygen required? No Yes: How long: _____

Difficulties sucking, swallowing, or feeding? No Yes: Specify _____

Describe any other unusual circumstances _____

Developmental History Any problems or concerns at all? No Yes

1. At what age did this child:

Sit alone: _____ Say his/her first word: _____
 Walk alone: _____ Understand speech: _____
 Use 2-word sentences: _____ Stop using baby talk: _____
 Become toilet trained during the day: _____
 Stop wetting the bed at night: _____

2. Did he/she have any problems in the following areas:

Learning the names of colors and shapes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Learning to tell time	<input type="checkbox"/> No <input type="checkbox"/> Yes
Learning to riding a 2-wheeled bicycle	<input type="checkbox"/> No <input type="checkbox"/> Yes	Learning to tie your shoes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Learning to climb stairs, hop, or skip	<input type="checkbox"/> No <input type="checkbox"/> Yes	Separating from parents	<input type="checkbox"/> No <input type="checkbox"/> Yes
Learning to use zippers or buttons	<input type="checkbox"/> No <input type="checkbox"/> Yes	Making friends	<input type="checkbox"/> No <input type="checkbox"/> Yes
Reading aloud in class	<input type="checkbox"/> No <input type="checkbox"/> Yes	Learning to read	<input type="checkbox"/> No <input type="checkbox"/> Yes
Learning the names or sounds of letters	<input type="checkbox"/> No <input type="checkbox"/> Yes	Learning to count or add	<input type="checkbox"/> No <input type="checkbox"/> Yes
Learning how to write letters or numbers	<input type="checkbox"/> No <input type="checkbox"/> Yes	Reciting the alphabet	<input type="checkbox"/> No <input type="checkbox"/> Yes
Learning right and left	<input type="checkbox"/> No <input type="checkbox"/> Yes	Learning to rhyme	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cutting with scissors	<input type="checkbox"/> No <input type="checkbox"/> Yes	Learning a second language	<input type="checkbox"/> No <input type="checkbox"/> Yes

Describe anything else hard for him/her to learn as a preschooler: _____

3. Did family, friends, etc. ever have difficulty understanding his/her speech? No Yes: Explain _____

4. Has this child ever been evaluated by or worked with an Occupational Therapist (OT)? No Yes:

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

5. Has this child ever been evaluated by or worked with a Physical Therapist (PT)? No Yes:

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

6. Has this child ever been evaluated by or worked with Speech/Language Pathologist (SLP)? No Yes:

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

7. Has this child ever been evaluated by or worked with a vision therapist/behavioral optometrist? No Yes:

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

8. Has this child ever had an audiological evaluation? No Yes:

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

9. Has this child ever participated in family or individual counseling or psychotherapy? No Yes:

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

Medical History

1. Childhood illness

Ear infections? No Yes: Age(s): _____ Explain: _____

P.E. tubes? No Yes: Age(s): _____ Explain: _____

Frequent colds? No Yes: Age(s): _____ Explain: _____

Allergies? No Yes: Age(s): _____ Explain: _____

Meningitis? No Yes: Age(s): _____ Explain: _____

Encephalitis? No Yes: Age(s): _____ Explain: _____

Whooping cough? No Yes: Age(s): _____ Explain: _____

Scarlet fever? No Yes: Age(s): _____ Explain: _____

Pneumonia? No Yes: Age(s): _____ Explain: _____

2. Has this child received any blows to the head? No Yes: When? _____

Unconscious? No Yes: For how long? _____

How did it happen? _____

3. Has this child ever had seizures? No Yes: Age(s) _____

Did this child receive medication? No Yes: Specify: _____

When was the last seizure? _____ Known cause for the seizure(s)? _____

4. Has this child ever been evaluated or treated for any stress, anxiety, depression, or other types of psychological problems? No Yes: List therapists and ages/dates of treatment

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

5. Has this child ever had injuries or accidents requiring medical treatment? No Yes: Specify _____

6. Has this child ever been hospitalized? No Yes: Age(s): _____

Why and for how long? _____

Current Medical Status

1. Describe this child's present health: _____ Last physical exam: _____

2. Last vision screening: _____ hearing screening: _____

3. Does this child wear glasses or contacts? No Yes: Age when prescribed ____ For what? _____

4. How is this child's appetite? _____
 Any recent changes (increased or decreased)? No Yes: Describe _____
5. Average amount of sleep at night: _____ Is this adequate to function well? No Yes
 Any recent changes (increased or decreased)? No Yes: Describe _____
 Any problems getting this child to go to bed and/or falling asleep? No Yes: Specify _____

 Typical bedtime school night: _____ Typical wake-up time school day: _____
6. Average number of hours: watching TV daily = _____ playing computer/video games daily = _____
7. Is your child sexually active? No Yes Is your child questioning gender identity/sexual preference? No Yes
8. Does your child drink alcohol, or use illegal drugs? No Yes Smoke cigarettes? No Yes
9. List current medications, including daily over-the-counter medications and dosage: _____

10. If applicable, list any other medications previously prescribed for a chronic illness or psychiatric or behavioral condition, and attach a separate page if necessary:

Type / Name	Dosage/ Frequency	When? (approx dates)	Reason

Educational History

1. List schools attended, including any/all day care centers and preschools:

School/Agency Name	City/State	Dates	Age/Grade

2. Check the box that best represents typical performance on standardized testing:

Reading:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Math:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Very Superior 98 th Percentile +	Superior 91 st -97 th	High Average 75 th -90 th	Average 25 th -75 th	Below Average 9 th -25 th	Borderline below 9 th percentile

3. Child's best subject(s)? _____

Child's weakest subject(s)? _____

4. Does this child have any trouble doing his/her homework independently? No Yes: Describe _____

5. How are problems with homework usually handled? _____

6. How often does this child write down assignments in an agenda or planner? _____

7. How much homework is usually turned in? _____

8. Did this child skip any grades in school? No Yes: Which? _____

9. Did this child repeat any grades in school? No Yes: Which? _____

Why? _____

10. What things were hard for this child to learn in elementary school (such as reading, math, writing cursive, succeeding in physical education, making and keeping friends, conduct, completing seatwork)?

11. How would this child's elementary school teachers describe him/her? _____

12. Describe any behavior problems during the elementary school years: _____

13. What things were hard for this child in middle and high school (such as writing compositions, reading long assignments, social skills, oral presentations, foreign language, algebra, geometry, study skills)?

14. How would this child's middle and high school teachers describe him/her? _____

15. Describe any behavior or conduct problems during the middle and high school years:

16. High school GPA _____ Average English grades _____ Average Math grades _____

17. Middle/High School foreign language instruction:

Language: _____ Grade(s): _____ Average course grades _____

18. List any honors, awards, or other kinds of special recognition this child has received: _____

19. Best PSAT score (if taken): Verbal _____ Math _____ Writing _____

Accommodations: No Yes: Describe _____

20. Best SAT score (if taken): Verbal _____ Math _____ Writing _____

Accommodations: No Yes: Describe _____

Prep course? No Yes: Specify _____

21. Best ACT score (if taken): _____

Accommodations: No Yes: Describe _____

Prep course? No Yes: Specify _____

22. Any other college or graduate school standardized tests (e.g., AP, GRE, GMAT, MCAT, LSAT, Praxis)?.

No Yes: Specify _____

23. Has this child ever worked with a private tutor? No Yes:

Grade(s) _____ Name _____ Reason _____

Grade(s) _____ Name _____ Reason _____

Grade(s) _____ Name _____ Reason _____

Grade(s) _____ Name _____ Reason _____

Grade(s) _____ Name _____ Reason _____

24. Has this child ever received any extra support in school? This would include work with a reading specialist, instructional specialist, para-educator, or school based tutor, placement in any special instructional groups or classes, or any kind of intervention plan, such as a 504 Plan, Accommodations Plan or IEP? No Yes:

Grade(s) _____ What? _____

Grade(s) _____ What? _____

Grade(s) _____ What? _____

Grade(s) _____ What? _____

Grade(s) _____ What? _____

Grade(s) _____ What? _____

Social/Emotional and Behavioral Functioning

1. How would other children describe this child? _____

2. Describe this child's friendships: A leader or follower? Easy to get along with? Older or younger friends?

3. Any problems in friendships (teasing, aggressiveness, rejection, etc.)? _____

4. Does this child have best friends, or a consistent group of friends whose company he/she regularly enjoys outside of school? _____
5. Is this child regularly invited by others to play, or to attend parties? No Yes: How often? _____
6. What kinds of things does this child enjoy? _____

7. How often does this child engage in physical activity? Rarely/Never 2-3 times/week most days
 Check all that apply: active free play with friends active play at recess PE class team sports / training
 gym – classes, weights, cardio, etc. solo/group running solo strength/conditioning other
8. List current extracurricular activities: _____

9. What household chores is he/she responsible for? _____

10. How does this child earn money? _____

11. What makes this child feel guilty? _____
12. How does this child show affection? _____
13. Is it hard for this child to trust others? No Yes: Does he/she feel comfortable around others? No Yes

14. How many times a week does this child feel really angry? _____ What makes him/her feel that way? _____
 _____ What does he/she do? _____

15. Are there significant conflicts between this child and either or both parents? No Yes
16. Is this child a worrier? No Yes: What types of types of things does he/she worry about? _____

17. Would you characterize this child as: "Driven" Easily stressed Perfectionistic? None of these
18. Does this child have trouble "pulling back?" No Yes
19. Describe any nervous habits (nail biting, thumb sucking, hair pulling, etc.) _____

20. Does this child have any history of self-injurious behaviors such as cutting? No Yes: Describe _____

21. Do you have any reason to believe this child is questioning his/her gender identity? No Yes
22. Do you have any reason to believe this child is questioning his/her sexual preference? No Yes
23. Would you describe this child as obedient, or compliant with requests? _____
24. How is he/she punished? _____
 For what and how often? _____
 Is it effective? _____
25. Any concerns, or history of, social stress or bullying? No Yes

26. Describe any unusual or problem behaviors not described above: _____

27. Any recent changes or stressors in this child's life, or in the family? _____ Describe: _____

28. On a scale of 1 to 10, rate the level of general stress in your home (with 10 = extremely stressful): _____

29. On average, how much time does this child spend with the father per week? _____

Typical activities together: _____

30. On average, how much time does this child spend with the mother per week? _____

Typical activities together: _____

31. Any other adults that this child regularly spends time with? _____

32. List any school suspensions or expulsions (dates and cause – attach school documentation if available)

33. Any concerns or history of self-harm, cutting, suicidal or homicidal thoughts? No Yes

Please explain: _____

34. Describe any unusual or intense fears, worries, shyness (currently or previously) _____

35. Describe any unusual behaviors, habits, rituals, etc. _____

36. Describe your child's typical disposition, mood _____

Current Issues and Plans

1. What is your purpose in seeking this evaluation? _____

2. What do you believe is the cause(s) of this child's difficulties _____

3. What have others – spouse, other parents, teachers, therapists, etc. – said might be the cause(s) of this child's difficulties _____

4. What do you think this child needs in order to be more successful, and to address the referral concerns:

5. This child's reaction/thoughts about this evaluation: _____

6. This child's physician's comments about his/her difficulties, and this evaluation: _____

7. How have you and/or this child coped with his/her learning problems? _____

8. How does this child best learn things? _____

9. Describe this child's strengths: _____

10. Additional comments: _____

If requesting a comprehensive evaluation of your child, please provide copies of the following records to supplement the information in this questionnaire. The more information that is provided to me, the better I can understand the context of the current difficulties or concerns that are prompting the request for testing. Please note that delays in getting these records to me will extend the projected timeline for completing the final evaluation report. These records include:

- Copies of all general educational records – including teacher comments, interim reports, report cards, anything you have. I want all report cards, for all years, and not just end-of-year grades
- Standardized testing reports – all standardized testing. If accommodations were provided, also provide documentation of this (for example, letters from the College Board, ACT, SSAT, or other testing agency)
- Copies of any special educational records – these might include informal and formal accommodation plans, behavior contracts, and for students in public schools, 504 plans and meeting notes, IEP's and meeting notes, RTI (Response to Intervention) plans and notes, SST/EMT documentation, etc.
- Formal and informal accommodation plans
- Copies of relevant medical records
- Informal records that can provide some useful background or contextual information, such as relevant emails to/from school or related service providers, or a screen shot of an online gradebook
- Work samples – writing samples particularly helpful to include
- All previous evaluation reports whether you agree with the conclusions or not, and including previous evaluations from all service providers such as speech/language, OT, and audiological evaluations
- Social-emotional / behavior questionnaires – I typically collect these from parents, teachers, and individuals being tested. It is important to assess or rule out emotional or behavioral impact of any educational, medical, or adjustment difficulties, and to obtain information from those who interact most with a student, especially when there are differences of opinion, so that I can address these differences appropriately. I will provide links for parents and teachers to complete these online in order to better ensure privacy and to avoid losing information in transit.

My signature below indicates that I have provided complete, true, and accurate information to the best of my knowledge, including all information regarding any previous testing. I understand that false or inaccurate information may invalidate the evaluation. If custody of this child is shared, I have made the other parent aware of this evaluation and invited his/her input on this or a separate questionnaire.

I also understand that information on this form, and any information provided as part of this evaluation, can be released only to individuals designated by me and with my written consent, and that my consent can also be revoked by me, in writing, at any time.

Signature

Date