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 ____________________________

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Current Family Information

1. Primary Parent 1's information

Name ____ Cell phone: ___________________________

Address (if different):____

Other Phone: _________________________________ Email: ____

Occupation: ______________________________ Age: _____ Highest Educational level: __________________

Any difficulties in learning, attention, mood or behavior? ☐ No ☐ Yes: Describe: ________________________

____

Any current or recent problems/stressors: ____

2. Primary Parent 2's information

Name ____ Cell phone: ___________________________

Address (if different):____

Other Phone: _________________________________ Email: ____

Occupation: ______________________________ Age: _____ Highest Educational level: __________________

Any difficulties in learning, attention, mood or behavior? ☐ No ☐ Yes: Describe: ________________________

____

Any current or recent problems/stressors: ____

3. Any significant (current) conflicts between parents? ☐ No ☐ Yes.

If parents are re-married, any significant marital conflicts on either side at the present time? ☐ No ☐ Yes

4. Other adults living in the child's home (part – or full-time): ☐ No ☐ Yes

Name ____ Cell phone: ___________________________

Relationship _______________________________ Occupation ______________________________________

Name ____ Cell phone: ___________________________

Relationship _______________________________ Occupation ______________________________________

5. Does this child have brothers or sisters? ☐ No ☐ Yes* (list all siblings, including step- / half- / adopted and indicate nature of relationship, and if the sibling lives in this child's primary home

Siblings' Names	**Age**	**Grade**	**Step ?**	**Ha lf ?**	**Adopted ?**	**lives with him/her?**	**Describe any difficulties in learning, attention, behavior, mood, or other disabilities**

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) and describe the nature of the condition, including undiagnosed problems.

Reading Problems ☐ No ☐ Yes Who? __________________ What?________________________

Learning Problems ☐ No ☐ Yes Who? __________________ What?________________________

Attention Problems ☐ No ☐ Yes Who? __________________ What?________________________

Behavior Problems ☐ No ☐ Yes Who? __________________ What?________________________

Mental Health Disorders ☐ No ☐ Yes Who? __________________ What?________________________

Mental Retardation ☐ No ☐ Yes Who? __________________ What?________________________

Epilepsy ☐ No ☐ Yes Who? __________________ What?________________________

Serious Chronic Illness ☐ No ☐ Yes Who? __________________ What?________________________

Speech/Language Problems ☐ No ☐ Yes Who? __________________ What?________________________

Drug/Alcohol Abuse ☐ No ☐ Yes Who? __________________ What?________________________

Trouble with the Law ☐ No ☐ 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 (provide best estimate if unsure, or check with your pediatrician):

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	□ No	□ Yes	Learning to tell time	□ No	□ Yes
Learning to ride a 2-wheeled bicycle	□ No	□ Yes	Learning to tie shoes	□ No	□ Yes
Learning to climb stairs, hop, or skip	□ No	□ Yes	Separating from parents	□ No	□ Yes
Learning to use zippers or buttons	□ No	□ Yes	Making friends	□ No	□ Yes
Reading aloud in class	□ No	□ Yes	Learning to read	□ No	□ Yes
Learning the names or sounds of letters	□ No	□ Yes	Learning to count or add	□ No	□ Yes
Learning how to write letters or numbers	□ No	□ Yes	Reciting the alphabet	□ No	□ Yes
Learning right and left	□ No	□ Yes	Learning to rhyme	□ No	□ Yes
Cutting with scissors	□ No	□ Yes	Learning a second language	□ No	□ 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. 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. Is your child sexually active? ☐ No ☐ Yes

9. Does your child drink alcohol, or use illegal drugs? ☐ No ☐ Yes Smoke cigarettes? ☐ No ☐ Yes

10. 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:	□	□	□	□	□	□
Math:	□	□	□	□	□	□
	Very Superior 98th Percentile +	Superior 91st-97th	High Average 75th-90th	Average 25th-75th	Below Average 9th-25th	Borderline below 9th percentile

3. Did this child skip any grades in school? □ No □ Yes: Which? ____

4. Did this child repeat any grades in school? □ No □ Yes: Which?______________________________________

Why?____

5. 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 _______________________________________

6. 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? ____

7. Has this child ever received any formal or informal testing accommodations for classroom tests? □ No □ Yes

8. Has this child ever received testing accommodations for standardized tests? □ No □ Yes

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

____

10. **PRESCHOOL**

Behavior problems? □ No □ Yes: Describe ____

Problems with speech/articulation? □ No □ Yes: Describe ____

Problems w/ friendships? □ No □ Yes: Describe ____

Concerns about activity level? □ No □ Yes: Describe ____

Any problems with early academic skills? □ No □ Yes: Describe __________________________________

11. **EARLY ELEMENTARY** (kindergarten – 2nd grade)

Strengths: ____

Areas of Concern: ____

Best subject(s)? ____

Weakest subject(s)? ____

Anything difficult to learn? ____

How would teachers describe him/her? ____

Any problems with homework? □ No □ Yes: Describe ____

Any problems with independent seatwork? □ No □ Yes: Describe __________________________________

Any concerns regarding attention, behavior? □ No □ Yes: Describe ________________________________

Any problems with social skills or friendships? □ No □ Yes: Describe _______________________________

Did/does this child like to read? □ No □ Yes

12. **LATER ELEMENTARY** (Grades 3 – 5)

Strengths: ____

Areas of Concern: ____

Best subject(s)? ____

Weakest subject(s)? ____

Anything difficult to learn? ____

How would teachers describe him/her? ____

Any problems with homework? □ No □ Yes: Describe ____

Frequency of parent oversight/help needed with homework? ______________________________ □ Never

Frequency of assignments written in planner/agenda? __________________________________ □ Never

Any problems with independent seatwork? □ No □ Yes: Describe __________________________________

Any concerns regarding attention, behavior? □ No □ Yes: Describe ________________________________

Any problems with social skills or friendships? □ No □ Yes: Describe _______________________________

Did/does this child like to read? □ No □ Yes

13. **MIDDLE SCHOOL** (Grades 6-8)

Strengths: ____

Areas of Concern: ____

Best subject(s)? ____

Weakest subject(s)? ____

Anything difficult to learn? ____

How would teachers describe him/her? ____

Any problems with homework? □ No □ Yes: Describe ______________________________________

Frequency of parent oversight/help needed with homework? __________________________ □ Never

Frequency of assignments written in planner/agenda? ______________________________ □ Never

How much homework is/was turned in? ____

Any concerns regarding attention, behavior? □ No □ Yes: Describe ____________________________

Any problems with social skills or friendships? □ No □ Yes: Describe __________________________

Any problems with foreign language learning? □ No □ Yes: Describe __________________________

Any problems with oral presentations? □ No □ Yes: Describe _________________________________

Any concerns regarding study skills? □ No □ Yes: Describe __________________________________

Did/does this child like to read? □ No □ Yes

14. **HIGH SCHOOL** (Grades 9-12)

Strengths: ____

Areas of Concern: ____

Best subject(s)? ____

Weakest subject(s)? ____

Anything difficult to learn? ____

How would teachers describe him/her? ____

Any problems with homework? □ No □ Yes: Describe ______________________________________

How often is parent oversight or help needed with homework? __________________________ □ Never

How often are assignments written in planner/agenda? ______________________________ □ Never

How much homework is/was turned in? ____

Any problems with group projects? □ No □ Yes: Describe ____________________________________

Any concerns regarding attention, behavior? □ No □ Yes: Describe ____________________________

Any problems with social skills or friendships? □ No □ Yes: Describe __________________________

Any problems with foreign language learning? □ No □ Yes: Describe __________________________

Any problems with oral presentations? □ No □ Yes: Describe _________________________________

Any concerns regarding study skills? □ No □ Yes: Describe __________________________________

Has this child worked with a test prep tutor for PSAT, ACT, SAT and/or AP exams? □ No □ Yes

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? ______________________________

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 <u>father</u> per week? ______________________________

Typical activities together: ______________________________

30. On average, how much time does this child spend with the <u>mother</u> 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 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 <u>your</u> 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: ____

____

____

____

____

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____

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.

Please provide copies of all records at (or prior to) the initial parent intake, and let me know if you have any questions.

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, invited his/her input on this or a separate questionnaire, and have obtained and provided consent of both parents if/as required for clinical services to be provided.

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