

## CHILD INTAKE FORM

Thank you for taking the time to complete this intake form. The information you provide here helps us to do a thorough evaluation of your child more efficiently. Please complete all items if possible. If you have any questions, please feel free to ask.

Name of person completing this form: \_\_\_\_\_ Date: \_\_\_\_\_

Child's name: \_\_\_\_\_

Birth date \_\_\_\_\_ Current age \_\_\_\_\_ Sex: M F

Home address \_\_\_\_\_

Home phone # \_\_\_\_\_ Parent/Guardian cell # \_\_\_\_\_

Child's school \_\_\_\_\_ Child's teacher \_\_\_\_\_

Grade \_\_\_\_\_ Special placement (if any) \_\_\_\_\_

Who referred you to The Connection Place? \_\_\_\_\_

Briefly describe the child's problems for which you would like help. Please be as specific as possible.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**FAMILY MEMBERS:** Name Age Occupation/Grade in School

Parent/Guardian \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Sibling \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Others \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### FAMILY HISTORY

Have any of the child's relatives (biological parents, grandparents, siblings, aunts, uncles, or close cousins) experienced the following? Please specify which relative.

\_\_\_\_\_ Reading problems \_\_\_\_\_

\_\_\_\_\_ Attention problems \_\_\_\_\_

\_\_\_\_\_ Hyperactivity \_\_\_\_\_

\_\_\_\_\_ Developmental disorders/mental retardation \_\_\_\_\_

\_\_\_\_\_ Addiction to alcohol or other drugs \_\_\_\_\_

\_\_\_\_\_ Severe depression \_\_\_\_\_

\_\_\_\_\_ Other significant mental illness or disorder \_\_\_\_\_

\_\_\_\_\_ Genetic syndromes \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_

### CURRENT FAMILY STRESSORS

Have any of the following stressful events occurred within the past 12 months?

\_\_\_\_\_ parents divorced or separated \_\_\_\_\_ death in family

\_\_\_\_\_ changed schools \_\_\_\_\_ family financial problems

\_\_\_\_\_ family accident or illness \_\_\_\_\_ parent changed job

\_\_\_\_\_ family moved \_\_\_\_\_ Other (please specify) \_\_\_\_\_

**During the following periods did your child have problems with any of these?**

**INFANCY** (first year)

Did not enjoy cuddling \_\_\_\_\_  
Was not calmed by being held or stroked \_\_\_\_\_  
Difficult to comfort \_\_\_\_\_  
Colic \_\_\_\_\_  
Excessive restlessness \_\_\_\_\_  
Excessive irritability \_\_\_\_\_  
Diminished sleep \_\_\_\_\_  
Frequent head banging \_\_\_\_\_  
Problems with nursing or taking bottle \_\_\_\_\_  
Constantly into everything \_\_\_\_\_

**TODDLER** (second to third year)

Excessively active \_\_\_\_\_  
Cranky/irritable \_\_\_\_\_  
Withdrawn/fearful \_\_\_\_\_  
Irregular patterns of sleep, appetite, habits \_\_\_\_\_

**Was your child on time, early, or late in reaching these developmental milestones?**

	On time	Early	Late
Sat up	_____	_____	_____
Walked	_____	_____	_____
Talked	_____	_____	_____
Bladder trained (day)	_____	_____	_____
Bladder trained (night)	_____	_____	_____
Bowel trained (day)	_____	_____	_____
Bowel trained (night)	_____	_____	_____
Reading	_____	_____	_____

**COMPREHENSION AND UNDERSTANDING**

Do you consider your child to understand directions and situations as well as other children his or her age? \_\_\_\_\_ If not, why not? \_\_\_\_\_

How would you rate your child's overall level of intelligence compared to other children?  
Below Average \_\_\_\_\_ Average \_\_\_\_\_ Above Average \_\_\_\_\_

**PRESENT MEDICAL STATUS**

Height \_\_\_\_\_ Weight \_\_\_\_\_  
Present illnesses for which the child is being treated \_\_\_\_\_  
Medications child is taking on ongoing basis \_\_\_\_\_  
Any physical abnormalities \_\_\_\_\_  
Name of your child's pediatrician or family doctor \_\_\_\_\_

**MEDICAL HISTORY**

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and give pertinent details:

Problems with pregnancy, labor, or delivery of child \_\_\_\_\_

Childhood diseases (describe ages and any complications) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Operations \_\_\_\_\_  
Hospitalizations for illness/surgery \_\_\_\_\_  
Loss of consciousness \_\_\_\_\_  
Head injuries \_\_\_\_\_  
Convulsions \_\_\_\_\_  
    with fever \_\_\_\_\_  
    without fever \_\_\_\_\_  
Coma \_\_\_\_\_  
Persistent high fevers \_\_\_\_\_  
Eye/vision problems \_\_\_\_\_  
Tics (Example: eye blinking, sniffing, any repetitive, non-purposeful movements) \_\_\_\_\_  
Ear/hearing problems \_\_\_\_\_  
Chronic ear infections/tubes \_\_\_\_\_  
Thyroid problems \_\_\_\_\_  
Allergies or asthma \_\_\_\_\_  
Poisoning \_\_\_\_\_  
Appetite/eating problems \_\_\_\_\_  
Unusual cravings \_\_\_\_\_  
Speech problems \_\_\_\_\_  
Sleep problems \_\_\_\_\_  
Clumsy/accident prone \_\_\_\_\_  
Problems with coordination \_\_\_\_\_  
Problems with sexual development \_\_\_\_\_

### **SCHOOL HISTORY**

Were you concerned about your child's ability to succeed in kindergarten? If so, explain:

\_\_\_\_\_

To the best of your knowledge, is your child at, above, or below grade level in the following subjects: Reading \_\_\_\_\_ Spelling \_\_\_\_\_ Math \_\_\_\_\_

Has your child ever had to repeat a grade? If so, when? \_\_\_\_\_

Present class placement: Regular class \_\_\_\_\_ Special class (Please specify) \_\_\_\_\_

\_\_\_\_\_

Has your child been evaluated at school for learning disabilities, emotional disturbance, academically gifted, etc.? If so, when and with what results? \_\_\_\_\_

\_\_\_\_\_

Kinds of special counseling or remedial work your child is currently receiving: \_\_\_\_\_

\_\_\_\_\_

Does your child's teacher describe any of the following as significant classroom problems?:

Doesn't sit still in his/her seat \_\_\_\_\_

Frequently gets up and walks around the classroom \_\_\_\_\_

Shouts out. Doesn't wait to be called on \_\_\_\_\_

Won't wait his/her turn \_\_\_\_\_

Doesn't cooperate well in group activities \_\_\_\_\_

Typically does better in a one-to-one relationship \_\_\_\_\_

Doesn't respect the rights of others \_\_\_\_\_

Doesn't pay attention during storytelling or show and tell \_\_\_\_\_

### **ADDITIONAL REMARKS**

Please use this space to make any additional remarks you wish regarding your child.

