CHILD INTAKE ASSESSMENT FORM

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IDENTIFYING INFORMATION

Child/Adolescent's Name: _____

Date of Birth: _____ Age: _____

Person(s) completing this form: _____

Child/Adolescent's legal guardian(s) is/are: _____

Child/Adolescent's Home Address: _____

City: _____ State: ____ Zip Code: _____

Race/Ethnicity (please check all that apply):
European-American ☐
African-American ☐
Hispanic-American ☐
Native-American ☐
Asian-American ☐
Other _____ ☐

Assigned Gender (gender assigned at birth): ☐ Male ☐ Female

Gender Identity: ☐ Female ☐ Male ☐ Transgender Male/FTM ☐ Transgender Female/MTF

☐ Non-binary/Genderqueer ☐ Other_____

Sexual Orientation: ☐ Lesbian ☐ Gay ☐ Straight/Heterosexual ☐ Bisexual

☐ Other _____ ☐ Choose not to disclose

MOTHER'S INFORMATION

Mother's name: _____ Date of birth: _____ Phone: _____

Address: _____

Highest Grade Completed: _____

Marital/relationship status (check one):
☐ Married ☐ Live with partner (check if opposite sex ☐ or same sex ☐)
☐ Single ☐ Separated/Divorced ☐ Widowed

Employment status (check all that apply):
☐ Employed ☐ Retired ☐ Disabled ☐ Student ☐ Homemaker ☐ Unemployed

Current employer is: _____

Years on Current Job: _____

FATHER'S INFORMATION

Father's name: _____ Date of birth: _____ Phone: _____

Address: _____

Highest Grade Completed: _____

Marital/relationship status (check one):

☐ Married ☐ Live with partner (check if opposite sex ☐ or same sex ☐)
☐ Single ☐ Separated/Divorced ☐ Widowed

Employment status (check all that apply):

☐ Employed ☐ Retired ☐ Disabled ☐ Student ☐ Homemaker ☐ Unemployed

Current employer is: _____

Years on Current Job: _____

STEP-PARENT'S INFORMATION

Step-parent's name: _____ Date of birth: _____ Phone: _____

Address: _____

Marital/relationship status (check one):

☐ Married ☐ Live with partner (check if same ☐ or opposite ☐ sex)
☐ Single ☐ Separated/Divorced ☐ Widowed or ☐ Other: _____

Current employer is: _____

Years on Current Job: _____

FAMILY

Is this child/adolescent adopted? ☐ Yes ☐ No

If yes, at what **age** were they **adopted** _____

If yes, does the child/adolescent know that they were adopted? ☐ Yes ☐ No

Has this child/adolescent ever experienced any parental separations and/or divorces? ☐ Yes ☐ No

If yes, when (month/year)? _____ Age of child/adolescent at the time? _____

Please describe the circumstances: _____

_____

If parents are separated or divorced, do they share joint legal custody of this child/adolescent?

☐ Yes ☐ No

If no, who has legal custody of this child/adolescent? _____

If separated or divorced, **please describe parenting time arrangement**: _____

_____

Please list the age and gender for each sibling (including step-siblings):

Age	Gender	Relationship to Child/Adolescent	Living at home?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Other than the parent(s) and individuals listed above, who else lives in the child's/adolescent's household?

_____

GENERAL BEHAVIORS/MOOD (Please check all that apply to your child/adolescent's typical behavior):

☐ Friendly/Outgoing	☐ Cooperative	☐ Respectful	☐ Optimistic
☐ Shy	☐ Prefers to be alone	☐ Prefers company	☐ Confident
☐ Stubborn	☐ Defiant	☐ Easygoing/calm	☐ Takes risks
☐ Irritable	☐ Pessimistic	☐ Expects failure	☐ Cautious
☐ Hardworking	☐ Caring	☐ Sharing	☐ Generally happy
☐ Lazy	☐ Uncaring	☐ Selfish	☐ Generally unhappy

PROBLEM BEHAVIORS (Please check all that apply to child/adolescent's recent or current behavior):

☐ Worries	☐ Tantrums/Angry outbursts	☐ Cruelty to animals
☐ Fears	☐ Impulsivity	☐ Reckless/Careless Behavior
☐ Obsessive thoughts	☐ Bullies	☐ Disruptive behavior
☐ Compulsive/Repetitive Behavior	☐ Argues	☐ Messy
☐ Odd thoughts	☐ Defiant/Oppositional	☐ Accident prone
☐ Odd behavior	☐ Fights	☐ Short attention span
☐ Disturbing thoughts	☐ Lies	☐ Distractible
☐ Missing school due to illness	☐ Steals	☐ Impulsive
☐ Frequent physical complaints	☐ Destroys property	☐ Hyperactive
☐ Learning problems	☐ Speech problems	☐ Poor school work
☐ Mood swings	☐ Sadness	☐ Depression
☐ Crying spells	☐ Irritable	☐ Withdrawn

REASON FOR SEEKING EVALUATION OR TREATMENT

Primary reason(s) you are seeking help for your child/adolescent?

_____

_____

_____

_____

When did your child/adolescent first start experiencing the problem(s) that brought you to the clinic?

_____

How often does the problem occur?_____

_____

Does your child/adolescent have any thoughts of harming themselves? ☐ Yes ☐ No

Has your child/adolescent ever attempted suicide? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Has your child/adolescent ever suffered from abuse?

Physical abuse? ☐ Yes ☐ No

Emotional abuse? ☐ Yes ☐ No

Sexual abuse? ☐ Yes ☐ No

If yes, please describe circumstances:

_____

_____

TREATMENT HISTORY

Has your child/adolescent received a **prior** psychological/neuropsychological evaluation(s)? ☐ Yes ☐ No

If yes, **when** was the evaluation (month/year)?_____

If yes, **reason** for the evaluation? _____

Current or past talk therapy/counseling for your child/adolescent? ☐ Yes ☐ No

If yes, start date (month/year)? _____

If yes, reason for treatment: _____

_____

_____

Has your child/adolescent ever been **hospitalized for emotional/behavioral problems?** ☐ Yes ☐ No

If yes, when and where: _____

_____

To your knowledge, has your child/adolescent experimented with drugs? ☐ Yes ☐ No

If yes, Tobacco? ☐ Yes ☐ No **Alcohol?** ☐ Yes ☐ No **Marijuana?** ☐ Yes ☐ No **Other?** _____

SIGNIFICANT LIFE EVENTS (Please check any of the following events that have occurred in your child/adolescent's life and their age when it occurred):

Event/Situation	**Age**	**Event/Situation**	**Age**
☐ Change of residence	____	☐ Family job problems	____
☐ Family substance abuse	____	☐ Family gambling problems	____
☐ Change of schools	____	☐ Family psychiatric problems	____
☐ Change of custody	____	☐ Family chronic illness	____
☐ Marital conflict	____	☐ Other family problems	____
☐ Parents separated	____	☐ Rejection by family member(s)	____
☐ Parents divorced	____	☐ Suffered/Witnessed accident or injury	____
☐ Parent visitation problems	____	☐ Severe fright or trauma	____
☐ Post-divorce parent conflict	____	☐ Death of family member or friend	____
☐ Parent(s) remarried	____	☐ Suicide of family member or friend	____
☐ Step-parent problems	____	☐ Death of pet	____
☐ Sibling birth	____	☐ Other _____	____
☐ Acquired step-sibling(s)	____	☐ Other _____	____

FAMILY HEALTH

Have any family members had any of the following (check if yes)?

If yes, please specify family member's relationship to this child/adolescent (i.e., parent, sibling, aunt, cousin, uncle, grandparent, etc.).

☐ Severe head injury _____ ☐ Autism Spectrum Disorder _____

☐ Tourette's syndrome _____ ☐ Cerebral palsy _____

☐ Food allergies _____ ☐ Alcohol/drug abuse_____

☐ Physical disability _____ ☐ Developmental Disability_____

☐ Seizures/epilepsy _____ ☐ Dementia/Alzheimer's_____

☐ Sleep Difficulties _____ ☐ Reading problems_____

☐ Speech/language problem _____ ☐ Tics (vocal and/or motor) _____

☐ Other Learning Problem _____ ☐ Anxiety_____

☐ Bipolar Disorder _____ ☐ ADHD_____

☐ Depression _____

☐ Other significant health, emotional, and/or behavioral problems: _____

_____

CHILD/ADOLESCENT'S EARLY DEVELOPMENT

Was this a planned pregnancy? ☐ Yes ☐ No

Was the birth mother under a doctor's care? ☐ Yes ☐ No

Number of previous pregnancies: _____ Number of miscarriages: _____

Delivery: ☐ Vaginal ☐ C-Section Length of labor: _____

Check any of the following health-related concerns and/or complications during the pregnancy:

☐ Fertility problems	☐ Vaginal bleeding	☐ Trauma
☐ High blood pressure	☐ Gestational diabetes	☐ Abnormal weight gain
☐ Fever/rash (e.g., flu, measles, etc.)	☐ Emotional problems	☐ Excessive vomiting
☐ Anemia	☐ Excessive swelling	☐ Alcohol
☐ Blood incompatibility	☐ Smoking	☐ Premature
☐ Illicit drugs	☐ Toxemia	☐ Fetal distress

☐ Other (Please describe):_____

☐ Hospitalization during pregnancy (Please describe):_____

_____

Please list any **medications** taken during pregnancy: _____

_____

At this child's birth, what was the **mother's age?** _____ **Father's age?** _____

Length of pregnancy: _____ weeks Birth weight: ____ lbs ____ oz.

Duration of labor: _____

Child's condition at birth: _____

Mother's condition at birth: _____

Length of stay in hospital: Mother _____ (# days) Child _____ (# days)

At what age was this child toilet trained? Days: _____ Nights: _____

Did bed-wetting occur after toilet training? ☐ Yes ☐ No If yes, until what age: _____

Did soiling occur after toilet training? ☐ Yes ☐ No If yes, until what age: _____

Describe your child's sleep patterns as an infant:_____

_____

_____

Language difficulties? ☐ Yes ☐ No If yes, describe: _____

_____

_____

Delays with child's walking? ☐ Yes ☐ No If yes, describe: _____

_____

_____

Other difficulties experienced during the child's first year? ☐ Yes ☐ No

If yes, describe: _____

_____

_____

Did your child have problems getting along with others prior to the age of 5? ☐ Yes ☐ No

If yes, describe: _____

_____

_____

CHILD/ADOLESCENT'S MEDICAL CARE AND PHYSICAL HEALTH

Child/Adolescent's pediatrician/family physician:_____

How often does this child/adolescent see a doctor? _____

Approximate date of **most recent visit**: _____

Is this child/adolescent currently prescribed medication? ☐ Yes ☐ No

If yes, please list each medication:

Medication

_____

_____

_____

_____

_____

_____

Does your child/adolescent have any history of the following (check all that apply):

☐ Hospitalizations
☐ High fevers
☐ Serious accidents
☐ Eye, ear, nose & throat problems
☐ Digestive disorder
☐ Head injuries
☐ Seizures
☐ Serious illness
☐ Allergies
☐ Loss of consciousness
☐ Surgeries

Please list below details of any conditions you checked above, including any additional childhood illnesses and other medical conditions:

Condition/hospitalization	Age	Outcome of treatment

CHILD/ADOLESCENT'S EDUCATION

Current school: _____

Child/adolescent's **current grade** (K through 12):_____

Describe any **academic problem**s your child/adolescent is having **in school**: _____

_____

_____

Describe any **emotional and/or behavioral problems** your child/adolescent is having **in school**:_____

_____

_____

Does your child/adolescent receive academic accommodations as part of a **504 Plan** or **special education services** (i.e., an IEP)? ☐ Yes ☐ No

If yes, describe:_____

CHILD/ADOLESCENT'S INTERESTS AND ACTIVITIES

Please list extracurricular activities in which your child/adolescent participates (i.e., clubs, sports, music, lessons, religious organizations, etc.):

_____

_____

Please describe your child/adolescent's strengths and positive characteristics:_____

_____

_____

_____

Other information you feel is important but wasn't asked about: _____

_____

_____

_____

_____

_____

_____

_____

Thank you for your time,

Dr. Jason G. Stentoumis