New Patient Intake Information

(Parent Report)

Welcome to the UA Whole Child Clinic! Our approach to treating your child is comprehensive and thorough. We consider various factors that contribute to your child's well-being including their behavior, growth and development, family, friends, school, physical health, diet, and physical activity. This intake form provides vital information about your child from your perspective as a parent. We hope you find that although the intake form is lengthy and requires an investment in time, it will allow us to understand your child and provide the best treatment.

To fill out this intake form, please allow at least 45 minutes so you can answer all of the questions accurately. All of the questions are very important for your psychiatrist to know about, so please take your time and answer as carefully as you can.

Because of our comprehensive approach, please allot 2 hours for the first appointment. After the first appointment, we may request to contact your child's school and therapist. Initial recommendations are usually given at the second appointment. At the first session, it is important that **caregivers** be present. For 2 parent families, both parents are HIGHLY encouraged to attend. In families with only a single parent, another key caregiver is invited to attend (if applicable).

Please bring the following with you to the first appointment, if available:

- ✓ Previous testing that has been done on your child (ex: neuropsychological testing, psychoeducational testing)
- ✓ Child's report card
- ✓ IEP (Individualized Education Program) or 504 plan if in place
- ✓ Testing done to create the IEP (Multi Factored Evaluation)
- ✓ All other relevant medical documents.
- ✓ All bottles/packages for all medications that the child is **currently** taking. This includes medications prescribed by a doctor, over the counter medications (ex: Tylenol), and all bottles of vitamins or nutritional supplements.
- ✓ Functional Behavior Assessments (FBA) and Behavior Intervention Plans (BIP)
- ✓ Legal paperwork establishing guardianship/custody arrangement (if applicable)

Thank you for choosing the UA Whole Child Clinic. We look forward to working with you and your child.

Today's Date: _____/_____/_____
Month Day Year

BACKGROUND AND CONTACT INFORMATION

Child's Name: _____
First Middle Last

Child's Date of Birth: _____/_____/_____ Child's Gender: ☐Male ☐Female
Month Day Year

Mother/Guardian Name: _____
First Middle Last

Best contact telephone number: (_____)_____-_____ ☐Check if a cell phone

Father/Guardian Name: _____
First Middle Last

Best contact telephone number: (_____)_____-_____ ☐Check if a cell phone

OTHER HEALTH AND MENTAL HEALTH PROVIDERS

Pediatrician or Primary Care Provider
Name: _____
Phone: (_____) _____

Counselor/ Therapist
Name: _____
Phone: (_____) _____

Psychiatrist
Name: _____
Specialty: _____
Phone: (_____) _____

Current School _____

School Phone: (_____) _____

Contact Name: _____

Current grade level: _____ Average grades: _____

Homework problems: _____

_____

CURRENT CONCERNS

Please describe your child's problem (s) (that is, the concerns that brought you here today):

When did these problems begin?

Please give examples of the problem:

Why do you think your child is having this particular problem?

CHALLENGING BEHAVIOR

1. Record each problem behavior the individual displays and describe it specifically. Include any damage resulting from the problem behavior either to the individual or others. Please rank in order of concern to yourself or other caretakers.

	Behavior	Description
A.	_____	_____
B.	_____	_____
C.	_____	_____
D.	_____	_____
E.	_____	_____
F.	_____	_____
G.	_____	_____

2. Estimate the severity of the problem behavior of greatest concern (circle one).
   Moderate Severe Life-threatening

3. Has the individual ever been sent to the hospital to treat an injury resulting from the behavior? Yes No Describe: _____

   _____

4. Has the individual ever sent someone else to the hospital to treat an injury resulting from the behavior? Yes No Describe: _____

   _____

5. Has the individual ever been hospitalized to develop a treatment for these behavior problems? Yes No Describe: _____

   _____

6. In what settings do these behaviors occur?
   a. Home
   b. School
   c. Community: specify_____
   d. Other:_____

7. Estimate the current frequency of the problem behavior(s) (circle one).

a. Less than one episode per week (list frequency)

b. 1 to 3 episodes per week.

c. Occurs about once daily.

d. Occurs several times per day.

e. Occurs every hour while awake.

8. How long has the individual been engaging in the problem behavior(s) (circle one)?

a. Within past 6 months.

b. More than 6 months but less than 1 year.

c. More than 1 year but less than 3 years.

d. More than 3 years but less than 5 years.

e. More than 5 years but less than 10 years.

f. More than 10 years.

9. When is the problem behavior(s) likely to occur (circle all that apply)

a. When individual is left alone or unattended.

b. When lots of people are around.

c. When demands are placed on the individual.

d. Mealtimes, dressing or bathing (circle).

e. Time of day:

g. Other:

10. Are there any occasions when the problem behavior(s) rarely or never occurs?

_____

_____

11. a. How do people (staff, parents, etc.) typically respond when the individual engages in the problem behavior(s)? (If a formal program is currently being conducted, refer to it here and send a copy. _____

b. How long has the program been in place? _____

12. Estimate the general trend of the problem behavior(s) during the past year (circle one).

a. Increasing (behavior getting worse).

b. Decreasing (behavior getting better).

c. Stable (about the same).

13. Does the individual display aggressive behavior toward staff or peers? If yes, explain:

_____

_____

_____

14. Was the onset of the problem behavior(s) associated with any specific event or series of events?

_____

_____

_____

Have the following procedures ever been used to treat the problem behavior(s) (circle all that have been used)?

a. Restraint.

Describe: _____

_____

Start Date: _____ Still used? Yes/No Stop Date: _____

Estimated degree of success:

_____

_____

_____

Which problem behavior(s) was the treatment indicated for?

_____

_____

b. Protective Equipment.

Describe: _____

_____

Start Date: _____ Still used? Yes/No Stop Date: _____

Estimated degree of success:

_____

_____

Which problem behavior(s) was the treatment indicated for?

_____

_____

_____

c. Behavior Modification - positive reinforcement.

Describe: _____

_____

Start Date: _____ Still used? Yes/No Stop Date: _____

Estimated degree of success:

_____

_____

Which problem behavior(s) was the treatment indicated for?

_____

_____

d. Behavior Modification - punishment.

Describe: _____

_____

Start Date: _____ Still used? Yes/No Stop Date: _____

Estimated degree of success:

_____

_____

Which problem behavior(s) was the treatment indicated for?

_____

_____

e. Other Describe: _____

_____

Start Date: _____ Still used? Yes/No Stop Date: _____

Estimated degree of success:

_____

_____

Which problem behavior(s) was the treatment indicated for?

_____

_____

What are your goals for consulting with our clinic? That is, what would you like to happen?

1. _____

2. _____

3. _____

4. _____

What feelings does your child MOST OFTEN show when faced with stress or other problems (i.e. anger, fear, sadness, etc.)

What seems to help your child deal with stress or problems?

What seems to make things worse?

LIFE STRESS

Major Stresses: Please mark if any of the following events have happened to your child in the past **TWO YEARS?** *Check all that apply.*

☐Moving to a new home
☐Change to a new school
☐Parents fighting
☐Parents separated
☐Parents divorced
☐New stepmother or stepfather
☐Mother or father **lost** a job
☐Mother or father got a **new** job
☐Change in parent's financial status
☐Increased absence of a parent
☐Parent in trouble with the law
☐Parent went to jail
☐Child had major personal injury/illness
☐Serious illness or injury in the family
☐Death of a family member
☐Serious illness of a friend
☐Boyfriend/girlfriend/friend having operation
☐Male: Girlfriend become pregnant
☐Female: Became pregnant
☐Death of a friend
☐Loss of a pet
☐Got a new pet
☐Got own car
☐New brother or sister
☐Trouble with a brother or sister
☐More arguments with parents
☐Less arguments with parents
☐Getting a new boyfriend/girlfriend
☐Breaking up with boyfriend/girlfriend
☐Making up with boyfriend/girlfriend
☐Losing a close friend
☐Got a new job
☐Lost a job
☐Special recognition for good grades
☐Making the honor role
☐Joining a new club
☐Making an athletic team, cheerleading, etc.
☐Failing to make athletic team, cheerleading, etc.
☐Trouble with teacher
☐Trouble with classmates
☐Making failing grades in school classes
☐Failed a grade/put back a grade
☐Skipped a grade/put ahead a grade
☐Got suspended from school
☐Got into trouble with the police
☐Got put into detention, jail

SLEEP

Where does your child sleep? *Please check all that apply.*

☐Own bed

☐Shares a bed. If so, with whom? _____

☐Other (ex: couch, floor, etc.

☐Own room

☐Shares a room. If so, with whom? _____

What time does child usually **go to bed** on **SCHOOL days**? _____

What time does child usually **go to bed** on **WEEKENDS**? _____

	15 minutes or less	16 – 30 minutes	31 – 60 minutes	61 minutes or more
How long (in minutes) does it usually take for child to fall asleep each night?	☐	☐	☐	☐

Problems falling asleep? ☐No ☐Yes If **yes**, please describe: _____

_____

Problems staying asleep? ☐No ☐Yes If **yes**, please describe: _____

_____

On **average**, how many **hours** does your child **sleep at night**?

☐Less than 6 hours ☐7 – 8 hours ☐9 hours ☐10 hours ☐More than 10 hours

What time does child usually **wake up** on **SCHOOL days**? _____

What time does child usually **wake up** on **WEEKENDS**? _____

Problems **waking up**? ☐No ☐Yes If **yes**, please describe: _____

How often does your child **take a nap**?

☐Never ☐1 – 2 days per week ☐3 – 6 days per week ☐Every day

Any **current** or **history** of: *Check all that apply*

☐ Loud Snoring	☐ Sleep Terrors	☐ Awaken gasping for breath or choking
☐ Restless Sleep	☐ Dry mouth	☐ Irresistible urge to move legs or arms
☐ Sleepy during the day	☐ Grinds teeth	☐ Bedwetting at night
☐ Mouth breathing	☐ Sleep Walking	☐ Recurrent nightmares
☐ Observed apnea (stops breathing) while sleeping		☐ Pain in legs at night

There is a **television** in my children's **room**. ☐Yes ☐No

CHILD'S LIFESTYLE (Diet, Physical Activity, Sleep, Screen Time)

A. Diet and Nutrition

Does your child have **food allergies or sensitivities**? ☐No ☐Yes

If **yes**, please list all food allergies and reaction: _____

_____

Is your child currently on a **special diet** (e.g., vegetarian, vegan, high protein, gluten free?) ☐ · No
☐Yes

If **yes**, please list dietary restrictions: _____

_____

How many **meals per week** does your **family eat together** where your child is present?

☐None ☐1 – 5 ☐6 – 10 ☐11 – 15 ☐16 or more

How many **mornings per week** does your **child eat breakfast**?

☐None ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

The next questions ask about the amount of certain foods and beverages your child eats on an AVERAGE day.

Soda (glasses, cups, or cans of Coke, Pepsi, etc)	☐None ☐1 ☐2 or more ☐Don't know
Caffeinated tea (cups of iced tea or hot tea)	☐None ☐1 ☐2 or more ☐Don't know
Caffeinated coffee (cups)	☐None ☐1 ☐2 or more ☐Don't know
Energy drinks (cans, glasses, or cups)	☐None ☐1 ☐2 or more ☐Don't know
Servings of fruit	☐None ☐1-2 ☐2-3 ☐4-5 ☐More than 5
Servings of vegetables	☐None ☐1-2 ☐2-3 ☐4-5 ☐More than 5

B. Physical Activity and Exercise

How many days a WEEK does your child spend at least 60 minutes in physical exercise that made child breathe hard and increase heart rate (ex: running, swimming, riding a bicycle, playing sports, etc)**:**

☐None ☐1-2 days ☐3-4 day ☐5-6 days ☐7 days

Does your child have and attend Physical education (PE) class at school:

☐Yes ☐No ☐Don't know

C. Screen Time

For an average day, how many hours does your child spend:

Watching television: _____ hours

Playing video games: (include online games, X Box, Play Station, iPad/tablet, iPhone/smartphone **_____ hours**

Using a computer (ex: for school work, searching the internet, emailing, Skype. DO NOT include video games) **_____ hours**

Cell phone, other electronic device (ex: for texting, talking with friends, etc) **_____ hours**

MEDICATIONS

Prescription Medications

What prescription medication is your child **currently** taking? Include **all** medications that have been **prescribed by a doctor** or other health care provider. **Include all CURRENT psychiatric medications**. (Please bring all medication bottles to your first visit!)

Name of Medication	Strength (Ex: 50 mg, 5 units)	Dose (Ex: 1 capsule daily, 1 teaspoon twice a day)	Reason Started	Side Effects

Vitamins, Minerals, Supplements, Over-the-Counter Medications. Please list all the vitamins, minerals, herbal medicines, and over the counter medications (ex: Tylenol) that your child is **currently** taking. (Please bring all bottles to your first visit)!

Name of Supplement or Over-the-Counter Medication	Strength (Ex: 50 mg, 5 units)	Dose (Ex: 1 capsule daily, 1 teaspoon twice a day)	Reason Started	Side Effects

Past Psychiatric Medications

What prescription psychiatric medications have been tried with your child **in the PAST**? Include **all** medications that have been **prescribed by a doctor** or other health care provider. (if you have them, please bring all medication bottles to your first visit!)

Name of Past Psychiatric Medication	Strength (Ex: 50 mg, 5 units)	Dose (Ex: 1 capsule daily, 1 teaspoon twice a day)	Reason Started	Side Effects

CHILD'S PAST PSYCHIATRIC OR MENTAL HEALTH CARE

Has your child EVER seen a therapist or counselor before (e.g., psychologist, social worker, school counselor)? ☐No ☐Yes

If **yes**, when and why: _____

_____

_____

Has your child EVER seen a psychiatrist before? ☐No ☐Yes

If **yes**, when and why: _____

_____

_____

Has your child EVER been admitted to the hospital for psychiatric treatment? ☐No ☐Yes

If **yes**, when and why: _____

_____

_____

CHILD'S MEDICAL HISTORY

Does your child have any CURRENT medical problems? ☐No ☐Yes

If **yes**, please describe: _____

Does the child have a history of?

☐Seizures ☐Concussions ☐Head traumas

☐Passing out ☐Palpitations (rapid heartbeat) ☐Heart murmur

☐Rheumatic fever ☐Chest pain or shortness of breath with exercise

☐High blood pressure

Does the child have a history of eczema: ☐No ☐Yes

If **yes**, when diagnosed: _____

Does the child have a history of reflux: ☐No ☐Yes

Other PAST medical problems: _____

_____

Drug allergies/intolerances: _____

History of surgeries: _____

FOR GIRLS:

Has your daughter begun menstruation (having her periods)? ☐No ☐Yes

If **yes**, at what age? _____

Are her menstrual cycles… ☐Regular (every 28 days) ☐Not regular (ex: 3 weeks, 5 weeks)

Does she have significant mood changes that go along with her monthly cycles? ☐No

☐Yes If **yes**, please describe: _____

_____

Does your daughter take birth control? ☐No ☐Yes

Review of Systems:

Please indicate by your child has had any of the following medical problems within the **past month**. *Check all that apply.*

General

☐Fever
☐Fatigue
☐Recent weight loss or gain
☐Restriction of numerous foods
☐Heat or cold intolerance
☐Difficulty sleeping

Head, Eyes, Ears, Nose, Mouth, Throat

☐Headache
☐Dizziness
☐Loss of hair
☐Swollen glands
☐Red or irritated eyes
☐Ringing in ears
☐Dry mouth
☐Bad breath
☐Mouth sores
☐Sore throat
☐Voice changes
☐Swollen glands
☐Running nose
☐Post nasal drip

Respiratory

☐Shortness of breath
☐Wheezing
☐Chest pain on taking a deep breath
☐Other cheast pain or tightness
☐Cough

Genitourinary

☐Pain with urination
☐Increase in frequency or urgency in urinating
☐Blood in urine

Cardiovascular

☐Irregular heart beat
☐Murmur
☐Palpitations

Bones, Muscles. Joints

☐Morning stiffness
☐Joint pain
☐Joint swelling
☐Muscle pain
☐Neck pain
☐Low back pain
☐Numbness or tingling

Skin

☐Rash over cheeks
☐Hives or welts
☐Easy bruising
☐Sun sensitivity
☐White, blue, or red skin color change in fingers when exposed to cold
☐Strong foot odor

Gastrointestinal

☐Loss of appetite
☐Difficulty swallowing
☐Heartburn, indigestion
☐Nausea
☐Vomiting
☐Pain or cramps in abdomen
☐Abnormal stool patterns
☐Bloated abdomen and gas/burping
☐Diarrhea
☐Constipation
☐Blood in stools
☐Vomiting blood

FAMILY HISTORY

Questions in this section are separated between biological parents and guardians/foster parents. If you are a guardian or foster parent, please first answer what you know about the child's biological mother and father. Then, move to the section about yourself.

BIOLOGICAL PARENTS

A. Biological Mother

Biological mother's current age: _____

If deceased, age at death: _____ Cause of death: _____

Biological mother's race/ethnicity:

- ☐ American Indian / Native American / Alaska Native
- ☐ Asian or Asian American
- ☐ Black / African American
- ☐ Hispanic / Latina
- ☐ White / Caucasian
- ☐ Other Pacific Islander
- ☐ Other _____
- ☐ Unknown

Biological mother's **highest** level of **completed education**?

- ☐ Elementary School only (grades 1-8)
- ☐ Some high school, but did not finish (grades 9-11)
- ☐ Completed high school or GED (high school graduate)
- ☐ Some college, but have not completed a degree
- ☐ Two-year college degree / A.A / A.S.
- ☐ Four-year college degree / B.A. / B.S.
- ☐ Some graduate work but have not completed a degree
- ☐ Completed a Masters degree or professional degree (e.g., ARNP)
- ☐ Completed a Ph.D., law degree, M.D., or similar advanced professional degree

Biological mother's **current employment** status?

- ☐ Employed full time
- ☐ Employed part time
- ☐ Unemployed / Looking for work
- ☐ Homemaker
- ☐ Retired

If employed full or part time, what is biological mother's **occupation or type of work**? _____

_____

Please describe the **medical** problems the **biological mother** may have: _____

_____

_____

Please describe any **behavioral/emotional problems** the **biological mother** may have: _____

_____

_____

Has the **biological mother** ever sought psychiatric treatment? ☐No ☐Yes

If **yes**, please explain the purpose: _____

_____

Has the **biological mother** ever had treatment or counseling for alcohol or drug use? ☐ · No ☐ · Yes

If **yes**, please explain: _____

_____

Does/has **anyone** on the **biological mother's side** of the family…

Take psychiatric medications? ☐No ☐Yes If **yes**, who, what medications, and why? _____

_____

Ever been hospitalized for a psychiatric problem? ☐No ☐Yes If **yes**, who and why? _____

_____

Ever been hospitalized for alcoholism or drug abuse? ☐No ☐Yes If **yes**, who and why? _____

_____

Ever **attempted** suicide? ☐No ☐Yes If **yes**, who? _____

Ever **committed/completed** suicide? ☐No ☐Yes If **yes**, who? _____

B. Biological Father

Biological father's current age: _____

If deceased, age at death: _____ Cause of death: _____

Biological father's race/ethnicity:

- ☐ American Indian / Native American / Alaska Native
- ☐ Asian or Asian American
- ☐ Black / African American
- ☐ Hispanic / Latina
- ☐ White / Caucasian
- ☐ Other Pacific Islander
- ☐ Other _____
- ☐ Unknown

Biological father's **highest** level of **completed education**?

- ☐ Elementary School only (grades 1-8)
- ☐ Some high school, but did not finish (grades 9-11)
- ☐ Completed high school or GED (high school graduate)
- ☐ Some college, but have not completed a degree
- ☐ Two-year college degree / A.A / A.S.
- ☐ Four-year college degree / B.A. / B.S.
- ☐ Some graduate work but have not completed a degree
- ☐ Completed a Masters degree or professional degree (e.g., ARNP)
- ☐ Completed a Ph.D., law degree, M.D., or similar advanced professional degree

Biological father's **current employment** status?

- ☐ Employed full time
- ☐ Employed part time
- ☐ Unemployed / Looking for work
- ☐ Homemaker
- ☐ Retired

If employed full or part time, what is biological father's **occupation or type of work**? _____

_____

Please describe the **medical** problems the **biological father** may have: _____

_____

_____

Please describe any **behavioral/emotional problems** the **biological father** may have: _____

_____

Has the **biological father** ever sought psychiatric treatment? ☐No ☐Yes

If **yes**, please explain the purpose: _____

Has the **biological father** ever had treatment or counseling for alcohol or drug use? ☐No ☐Yes

If **yes**, please explain: _____

_____

Does/has **anyone** on the **biological father's side** of the family:

Take psychiatric medications? ☐No ☐Yes If **yes**, who, what medications, and why? _____

_____

Ever been hospitalized for a psychiatric problem? ☐No ☐Yes If **yes**, who and why? _____

_____

Ever been hospitalized for alcoholism or drug abuse? ☐No ☐Yes If **yes**, who and why? _____

_____

Ever **attempted** suicide? ☐No ☐Yes If **yes**, who? _____

Ever **committed/completed** suicide? ☐No ☐Yes If **yes**, who? _____

If your child is NOT adopted, please SKIP this section, and resume at "Family Medical History"

ADOPTIVE PARENTS

How long has this child been with you? _____

Are you related to the child (ex: grandparent, aunt/uncle)?

☐No ☐Yes If **yes**, how related? _____

Mother. In the following questions, "mother" refers to the foster mother or adoptive mother.

Mother's current age: _____

Mother's race/ethnicity:

- ☐ Black / African American
- ☐ Hispanic / Latina
- ☐ White / Caucasian
- ☐ Other Pacific Islander
- ☐ Other _____
- ☐ Unknown

Mother's **highest** level of **completed education**?

- ☐ Elementary School only (grades 1-8)
- ☐ Some high school, but did not finish (grades 9-11)
- ☐ Completed high school or GED (high school graduate)
- ☐ Some college, but have not completed a degree
- ☐ Two-year college degree / A.A / A.S.
- ☐ Four-year college degree / B.A. / B.S.
- ☐ Some graduate work but have not completed a degree
- ☐ Completed a Masters degree or professional degree (e.g., ARNP)
- ☐ Completed a Ph.D., law degree, M.D., or similar advanced professional degree

Mother's **current employment** status?

- ☐ Employed full time
- ☐ Employed part time
- ☐ Unemployed / Looking for work
- ☐ Homemaker
- ☐ Retired

If employed full or part time, what is mother's **occupation or type of work**? _____

_____

Please describe the **medical** problems the **mother** may have: _____

Please describe any **behavioral/emotional problems** the **mother** may have: _____

_____

Has the **mother** ever sought psychiatric treatment? ☐No ☐Yes

If **yes**, please explain the purpose: _____

Has the **mother** ever had treatment or counseling for alcohol or drug use? ☐No ☐Yes

If **yes**, please explain: _____

_____

Does/has **anyone** on the **mother's side** of the family…

Take psychiatric medications? ☐No ☐Yes If **yes**, who, what medications, and why? _____

_____

Ever been hospitalized for a psychiatric problem? ☐No ☐Yes

If **yes**, who and why? _____

_____

Ever been hospitalized for alcoholism or drug abuse? ☐No ☐Yes

If **yes**, who and why? _____

_____

Ever **attempted** suicide? ☐No ☐Yes

If **yes**, who? _____

_____

Ever **committed/completed** suicide? ☐No ☐Yes

If **yes**, who? _____

_____

Non-Biological Father. In the following questions, "father" refers to the foster or adoptive father.

Father's current age: _____

Father's race/ethnicity:

- ☐ Black / African American
- ☐ Hispanic / Latina
- ☐ White / Caucasian
- ☐ Other Pacific Islander
- ☐ Other _____
- ☐ Unknown

Father's **highest** level of **completed education**?

- ☐ Elementary School only (grades 1-8)
- ☐ Some high school, but did not finish (grades 9-11)
- ☐ Completed high school or GED (high school graduate)
- ☐ Some college, but have not completed a degree
- ☐ Two-year college degree / A.A / A.S.
- ☐ Four-year college degree / B.A. / B.S.
- ☐ Some graduate work but have not completed a degree
- ☐ Completed a Masters degree or professional degree (e.g., ARNP)
- ☐ Completed a Ph.D., law degree, M.D., or similar advanced professional degree

Father's **current employment** status?

- ☐ Employed full time
- ☐ Employed part time
- ☐ Unemployed / Looking for work
- ☐ Homemaker
- ☐ Retired

If employed full or part time, what is father's **occupation or type of work**? _____

_____

Please describe the **medical** problems the **father** may have: _____

_____

Please describe any **behavioral/emotional problems** the **father** may have: _____

_____

Has the **father** ever sought psychiatric treatment? ☐No ☐Yes

If **yes**, please explain the purpose: _____

_____

Has the **father** ever had treatment or counseling for alcohol or drug use? ☐No ☐Yes

If **yes**, please explain: _____

_____

Does/has **anyone** on the **father's side** of the family:

Take psychiatric medications? ☐No ☐Yes If **yes**, who, what medications, and why? _____

_____

Ever been hospitalized for a psychiatric problem? ☐No ☐Yes If **yes**, who and why? _____

_____

Ever been hospitalized for alcoholism or drug abuse? ☐No ☐Yes If **yes**, who and why? _____

_____

Ever **attempted** suicide? ☐No ☐Yes If **yes**, who? _____

Ever **committed/completed** suicide? ☐No ☐Yes If **yes**, who? _____

FAMILY MEDICAL HISTORY

Does anyone in your child's BIOLOGICAL FAMILY have a history of?

Sudden or unexplained death in someone young?	☐No	☐Yes
Sudden cardiac death or "heart attack" in members younger than 35 years of age?	☐No	☐Yes
Sudden death during exercise?	☐Yes	☐No
Cardiac arrhythmias?	☐No	☐Yes
Hypertrophic cardiomyopathy or other cardiomyopathy?	☐No	☐Yes
Long QT syndrome, short-QT syndrome or Brugada syndrome?	☐Yes	☐No
Wolff-Parkinson-White syndrome?	☐No	☐Yes
Marfan syndrome?	☐No	☐Yes
Celiac disease?	☐No	☐Yes

If **yes**, please describe: _____

_____

CAREGIVER STRESS LEVEL

TO BE FILLED OUT BY THE MAIN CAREGIVER. Answer these questions about **YOUR** level of stress.

	Not at all	A little bit	Moderate amount	A good deal	Very much
Stress means a situation in which a person feels tense, restless, nervous or anxious, or is unable to sleep at night because his/her mind is troubled all the time. How much do you feel this kind of stress **these days (at the present time)**?	○ 1	○ 2	○ 3	○ 4	○ 5

	No stress						Extreme stress
In the **past year**, how would you rate the amount of stress you have in your life, at home and at work?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6

These questions ask about your feelings and thoughts during the **PAST TWO WEEKS** (14 days). For each, please indicate how often you felt or thought a certain way.

	Never	Almost never	Some times	Fairly often	Very often
How often have you felt that you were unable to control the important things in your life?	○ 0	○ 1	○ 2	○ 3	○ 4
How often have you felt confident about your ability to handle your personal problems?*	○ 0	○ 1	○ 2	○ 3	○ 4
How often have you felt that things were going your way?*	○ 0	○ 1	○ 2	○ 3	○ 4
How often have you felt difficulties were piling up so high that you could not overcome them?	○ 0	○ 1	○ 2	○ 3	○ 4

	I can shake off stress						Stress eats away at me
In general, how would you rate your ability to handle stress?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6

CHILD'S DEVELOPMENTAL HISTORY

A. Prenatal History and Mother's Health During Pregnancy

Was the pregnancy with this child: ☐Planned ☐Unplanned ☐Unknown

Did this pregnancy have any of the following complications? *Please check all that apply.*

☐Bleeding ☐Excessive vomiting
☐Needed medications ☐Infections
☐Needed x-rays ☐Other : _____

During pregnancy, did mother… *Please check all that apply*

☐Smoke cigarettes ☐Drink alcohol ☐Use medical marijuana ☐Use illegal drugs ☐Unknown

Other complications or events during pregnancy? Please describe: _____

_____

_____

Was mother depressed **during** pregnancy? ☐No ☐Yes ☐Unknown

If **yes**, how long did it last? _____

Was **mother** depressed **after** pregnancy? ☐No ☐Yes ☐Unknown

If **yes**, how long did it last? _____

Was **father** depressed **after** pregnancy? ☐No ☐Yes ☐Unknown

If **yes**, how long did it last? _____

B. Birth and Postnatal Period

Where was this child born? _____

City State Country

Was the delivery: ☐Vaginal ☐C Section ☐Unknown

Child's weight at birth: _____ pounds _____ ounces ☐Unknown

Child's length at birth: _____ inches ☐Unknown

Child's **primary** caregiver in the **first year**: ☐Mother ☐Father ☐Other: _____

Child's **primary** caregiver **after** the **first year**: ☐Mother ☐Father ☐Other: _____

Was child **breast fed?** ☐No ☐Yes ☐If yes, until what age?: _____

Did child have a history of **colic?** ☐No ☐Yes

C. DEVELOPMENTAL HISTORY

If you can recall, please record the age at which your child reached the following developmental milestones. If you cannot recall the age, please check the box that best describes when the milestones were reached.

	Age	**Best recollection, if exact age is not recalled**		
Sat without support	_____	☐Early	☐Normal	☐Late
Crawled	_____	☐Early	☐Normal	☐Late
Stood without support	_____	☐Early	☐Normal	☐Late
Walked without assistance	_____	☐Early	☐Normal	☐Late
Bowel trained	_____	☐Early	☐Normal	☐Late
Bladder trained, day	_____	☐Early	☐Normal	☐Late
Bladder trained, night	_____	☐Early	☐Normal	☐Late
Tied shoelaces	_____	☐Early	☐Normal	☐Late
Rode bicycle	_____	☐Early	☐Normal	☐Late

Did your child ever receive Early Intervention? ☐No ☐Yes

If yes, please describe: _____

_____

D. LANGUAGE DEVELOPMENT

Please indicate the **child's age** when the following **language milestones** were reached. (Beside each question is the age most children reach the milestone. They may not be the same for your child).

- Several words besides mama and dada (1 year) _____
- Naming several objects: ball, cup, etc. (15 months) _____
- Three words together: subject, verb, object (2 years) _____

When compared to peers, was there any problem with vocabulary, articulation, and comprehension?

☐No ☐Yes ☐If yes, describe_____

_____

Has your child ever received speech therapy? ☐No ☐Yes

If yes, at what age: _____

E. SOCIAL DEVELOPMENT

Please indicate the **child's age** when the following **social milestones** were reached. (Beside each question is the age most children reach the milestone. They may not be the same for your child).

- Smiled (2 mo) _____
- Shy with strangers (6 - 10 mo) _____
- Separates from parent easily (2-3 yrs) _____
- Cooperative play with others (4 yrs) _____

Were there problems with **attachment** with mother or father?

☐No ☐Yes ☐If yes, describe_____

_____

Were there problems when the child was **first separating** from home, for example when starting daycare/preschool/**kindergarten**/first grade?

☐No ☐Yes ☐If yes, describe_____

_____

Problems in relationships with **other family members**? (Include siblings)

☐No ☐Yes ☐If yes, describe_____

_____

Problems in **past peer interactions**. That is, has the child had difficulty getting along with friends?

☐No ☐Yes ☐If yes, describe_____

_____

Friendships

Does your child get along with other children **currently**? ☐Yes ☐No

Does your child **get invited** for sleepovers or birthday parties? ☐Yes ☐No

Does your child **attend** sleepovers or birthday parties? ☐Yes ☐No

Does your child have a best friend? ☐Yes ☐No

Animals

Does your child have any fears of animals? ☐Yes ☐No

Does your child have a pet now or had a pet in the past? ☐Yes ☐No

Pet's name (s):

_____

_____

F. EMOTIONAL DEVELOPMENT

Each child is BORN with a natural form of interacting with people, places, and things. This is called their "temperament." Of the following, how would you describe your child's temperament?

- ☐ **Easy or flexible** children are generally calm, happy, regular in sleeping and eating habits, adaptable, and not easily upset. Because of their easy style, parents need to set aside special times to talk about the child's frustrations and hurts because he or she won't demand or ask for it.
- ☐ **Difficult, active, or feisty** children are often fussy, irregular in feeding and sleeping habits, fearful of new people and situations, easily upset by noise and commotion, high strung, and intense in their reactions.
- ☐ **Slow to warm up or cautious** children are relatively inactive and fussy, tend to withdraw or to react negatively to new situations, but their reactions gradually become more positive with continuous exposure.

Does your child have **fears/phobias** (ex: the dark, snakes, clowns, etc.)

☐No ☐Yes ☐If yes, describe_____

_____

Does your child have **special objects** (blanket, dolls, etc.)

☐No ☐Yes ☐If yes, describe_____

_____

HOUSING AND HOUSEHOLD

A. Child's Housing. Which of the following best describes your child's **current** housing situation?

☐Own single/multiple family home ☐Boarding school ☐Homeless
☐Rented apartment ☐Group home
☐Rented house ☐Shelter
☐Subsidized housing (e.g., HUD) ☐Residential treatment

What is the **primary language** spoken in the **home**? _____

Do you have any concerns about the **security or safety of the home or neighborhood**? ☐ · No
☐ · Yes

If **yes**, please describe? _____

Who are the individuals living in the home? Please include ALL adults and children.

Name	Relationship	Age

For this **current year**, what do you expect your **family income from all sources before taxes** to be?

☐Under $25,000
☐$25,000 - $39,999
☐$40,000 - $49,999
☐$50,000 - $74,999
☐$75,000 - $99,999
☐$100,000 - $124,999
☐$125,000 - $149,999
☐Over $150,000 Prefer not to disclose
☐Prefer not to disclose

LEGAL

Has Child Protective Services ever been involved in your family's life? ☐No ☐Yes

If **yes**, please describe: _____

_____

Does a **parent** or **child** have a history with the legal system? ☐No ☐Yes

If **yes**, please describe: _____

_____

FAMILY RELIGIOUS/SPIRITUAL BELIEFS

Does your family attend religious services? ☐No ☐Yes If **yes**, please describe? _____

_____

Is your child involved in a youth group through your family's religion? ☐No ☐Yes

If **yes**, please describe? _____

What religious/spiritual dimensions should we consider in planning your child's care, if any? _____

_____

DISCIPLINE

What disciplinary techniques do you use with your child? _____

_____

Have these techniques been effective? ☐No ☐Yes

What methods of discipline seem to work best with the child? _____

_____

SCHOOL HISTORY

Does the child currently have a **learning disability** or a **history** of a learning disability? ☐No ☐Yes

If **yes**, please describe: _____

_____

_____

Comments from teachers: _____

_____

_____

Other school/educational concerns: _____

_____

Does the child have an **IEP** (Individualized Education Program)? ☐No ☐Yes

If **yes**, what are the accommodations? _____

_____

Are you satisfied with the accommodations? ☐No ☐Yes

Does the child have a **504 plan**? ☐No ☐Yes

If **yes**, what are the accommodations? _____

_____

Are you satisfied with the accommodations? ☐No ☐Yes

ADDITIONAL INFORMATION

Is there any additional information you would like us to know or which you believe will be helpful to better understand your child?

Thank you for helping us help you and your child!