**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 caregiver**S** 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.
* 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

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| **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

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| **OTHER HEALTH AND MENTAL HEALTH PROVIDERS** |

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| **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:

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| **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?**

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

1.

2.

3.

4.

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| **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 | New brother or sister |
| Change to a new school | Trouble with a brother or sister |
| Parents fighting | More arguments with parents |
| Parents separated | Less arguments with parents |
| Parents divorced | Getting a new boyfriend/girlfriend |
| New stepmother or stepfather | Breaking up with boyfriend/girlfriend |
| Mother or father **lost** a job | Making up with boyfriend/girlfriend |
| Mother or father got a **new** job | Losing a close friend |
| Change in parent’s financial status | Got a new job |
| Increased absence of a parent | Lost a job |
| Parent in trouble with the law | Special recognition for good grades |
| Parent went to jail | Making the honor role |

|  |  |
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| Child had major personal injury/illness | Joining a new club |
| Serious illness or injury in the family | Making an athletic team, cheerleading, etc. |
| Death of a family member | Failing to make athletic team, cheerleading, etc. |
| Serious illness of a friend | Trouble with teacher |
| Boyfriend/girlfriend/friend having operation | Trouble with classmates |
| Male: Girlfriend become pregnant | Making failing grades in school classes |
| Female: Became pregnant | Failed a grade/put back a grade |
| Death of a friend | Skipped a grade/put ahead a grade |
| Loss of a pet | Got suspended from school |
| Got a new pet | Got into trouble with the police |
| Got own car | Got put into detention, jail |

**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?**

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| **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**?

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

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

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| **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**

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| **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 |
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**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)!

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| --- | --- | --- | --- | --- |
| 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 |
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**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 |
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| **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:

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| **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 heart beat) 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** | **Cardiovascular**  |
| Fever | Irregular heart beat |
| Fatigue | Murmur |
| Recent weight loss or gainRestriction of numerous foods | Palpitations |
| Heat or cold intolerance | **Bones, Muscles. Joints** |
| Difficulty sleeping | Morning stiffness |
| **Head, Eyes, Ears, Nose, Mouth, Throat** | Joint painJoint swelling |
| Headache | Muscle pain |
| DizzinessLoss of hair | Neck painLow back pain |
| Swollen glands | Numbness or tingling |
| Red or irritated eyes |  |
| Ringing in ears | **Skin** |
| Dry mouthBad breath | Rash over cheeksHives or welts |
| Mouth soresSore throat | Easy bruisingSun sensitivity |
| Voice changesSwollen glands | White, blue, or red skin color change in fingers when exposed to cold |
| Running nosePost nasal drip**Respiratory** | Strong foot odor**Gastrointestinal** |
| Shortness of breathWheezing | Loss of appetiteDifficulty swallowing |
| Chest pain on taking a deep breath | Heartburn, indigestion |
| Other cheast pain or tightness | Nausea |
| Cough | Vomiting |
|  | Pain or cramps in abdomen |
| **Genitourinary** | Abnormal stool patterns |
| Pain with urination | Bloated abdomen and gas/burping |
| Increase in frequency or urgency in urinating | Diarrhea |
| Blood in urine | Constipation |
|  | Blood in stools |
|  | Vomiting blood |

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| **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 your related to the child (ex: grandparent, aunt/uncle)?

 No Yes If **yes**, how related?

**Mother.** In the followingquestions, “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 followingquestions, “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? No Yes

Cardiac arrhythmias? No Yes

Hypertropic cardiomyopathy or other cardiomyopathy? No Yes

Long QT syndrome, short-QT syndrome or Brugada syndrome? No Yes

Wolff-Parkinson-White syndrome? No Yes

Marfan syndrome? No Yes

Celiac disease ? No Yes

If **yes**, please describe:

|  |
| --- |
| **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** |  |  | **Animals** |  |  |
| Does your child get along with other children **currently**? | Yes | No | Does your child have any fears of animals? | Yes | No |
| Does your child **get invited** for sleepovers or birthday parties? | Yes | No | Does your child have a pet now or had a pet in the past? | Yes | No |
| Does your child **attend** sleepovers or birthday parties? | Yes | No |  Pet’s name (s):  |
| Does your child have a best friend? | Yes | No |   |

**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?

Havethese 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!**