

INTAKE QUESTIONNAIRE

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Respondent's Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

I. Prenatal and Birth History (Provide additional details on back of page)

Birth Weight \_\_\_\_\_ Apgar Scores \_\_\_\_\_

Length of Pregnancy \_\_\_\_\_ Duration of Labor \_\_\_\_\_

Was the delivery difficult? \_\_\_\_\_ Breech? \_\_\_\_\_ Instrument assist? \_\_\_\_\_

Induced? \_\_\_\_\_ Caesarian? \_\_\_\_\_ Emergency C-section? \_\_\_\_\_

Previous miscarriages or difficult pregnancies? \_\_\_\_\_

Type(s) of medication taken by mother during pregnancy (include alcohol and nonprescription) \_\_\_\_\_

Illnesses and emotional stresses of mother \_\_\_\_\_

Rubella or German measles while pregnant? \_\_\_\_\_ Rh negative? \_\_\_\_\_

Was cord looped around neck? \_\_\_\_\_ Baby blue or dusky color \_\_\_\_\_

Difficulty beginning to breathe? \_\_\_\_\_ Administered oxygen? \_\_\_\_\_

Baby placed in intensive care? How long? \_\_\_\_\_ Hospital? \_\_\_\_\_

II. Living Circumstances

Child is living with:

\_\_\_\_\_ Natural mother                      \_\_\_\_\_ Natural father

\_\_\_\_\_ Adoptive mother                      \_\_\_\_\_ Adoptive father

\_\_\_\_\_ Stepmother                      \_\_\_\_\_ Stepfather

Visits with \_\_\_\_\_ noncustodial divorced parent

Siblings:	Name	Age	Grade in school
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Frequent moves and relocations of the family? \_\_\_\_\_

Protracted custody or visitation conflicts? \_\_\_\_\_

Family controversies surrounding adoption? \_\_\_\_\_

Care giving responsibilities distributed unevenly or inconsistently?  
 \_\_\_\_\_ Primary caregiver \_\_\_\_\_

Relationship child has with siblings \_\_\_\_\_

### III. Developmental Milestones and Behavioral Characteristics

Age's child completed the following:

Sat erect without support \_\_\_\_\_ Walked alone \_\_\_\_\_

Spoke in 2 and 3 word sentences \_\_\_\_ Toilet trained Day \_\_\_\_ Night \_\_\_\_

Attended group day care \_\_\_\_\_ Preschool \_\_\_\_\_ Kindergarten \_\_\_\_\_

Describe the following:

Sleeping patterns \_\_\_\_\_

Eating habits \_\_\_\_\_

Friendships \_\_\_\_\_

Responds to new situations \_\_\_\_\_

Check which of the following is true about your child:

- \_\_\_\_\_ Developmental milestones achieved about same time as siblings.
- \_\_\_\_\_ Crawled in unusual fashion; sideways, dragging one leg, on one hip.
- \_\_\_\_\_ Did not creep or crawl much before walking.
- \_\_\_\_\_ Speech has been slow, halting, difficult to comprehend, stuttering.

- \_\_\_\_\_ Did not speak clearly until about 4 or 5 years of age.
- \_\_\_\_\_ Speech was odd, bizarre and unrelated to immediate experiences.
- \_\_\_\_\_ Seems awkward in walking, running, or working with hands.
- \_\_\_\_\_ Prefers using different hands for different activities; writing, eating.
- \_\_\_\_\_ Seems to use foot opposite his dominant hand for kicking.
- \_\_\_\_\_ Did not seem to do well with crayons or coloring.
- \_\_\_\_\_ Usually uses only one hand at a time without assistance from the other.
- \_\_\_\_\_ Has trouble with handwriting.
- \_\_\_\_\_ Reverses words or letters in writing. Age when this stopped \_\_\_\_\_
- \_\_\_\_\_ Has trouble spelling.
- \_\_\_\_\_ Has trouble reading.
- \_\_\_\_\_ Reverses words or letter while reading. Age when this stopped \_\_\_\_\_
- \_\_\_\_\_ Can read but does not seem to understand what was just read.
- \_\_\_\_\_ Has trouble working with numbers.
- \_\_\_\_\_ Has difficulty concentrating.
- \_\_\_\_\_ Easily distracted by sounds.
- \_\_\_\_\_ Easily distracted by people or things moving.
- \_\_\_\_\_ Has a short attention span.
- \_\_\_\_\_ Has trouble waiting or seems to act without thinking.
- \_\_\_\_\_ Finds it difficult to sit still. Tends to be overactive.
- \_\_\_\_\_ Cries easily.
- \_\_\_\_\_ Has repeated a grade in school. Grade(s) repeated \_\_\_\_\_

IV. Medical History (Continued)

Check any of the following that currently apply or have in the past applied to your child. Use the back of the page for further explanation if necessary.

- \_\_\_\_\_ Vision problems \_\_\_\_\_
- \_\_\_\_\_ Hearing problems or frequent ear infections \_\_\_\_\_
- \_\_\_\_\_ Frequent Strep infections \_\_\_\_\_
- \_\_\_\_\_ Allergies \_\_\_\_\_
- \_\_\_\_\_ Seizure condition \_\_\_\_\_
- \_\_\_\_\_ Physical disabilities \_\_\_\_\_
- \_\_\_\_\_ Heart condition \_\_\_\_\_

\_\_\_\_ Kidney condition \_\_\_\_\_

\_\_\_\_ Wets the bed \_\_\_\_\_

\_\_\_\_ Hydrocephalus \_\_\_\_\_

Family history of dyslexia, school problems, emotional illness, addictive disorders \_\_\_\_\_

Describe social, economic or emotional traumas your child has experienced (e.g. death in family, illnesses, abuse, separation from family)

\_\_\_\_\_

V. Observations and Questions

What do you believe are the primary problems and causes to the problems that your child is experiencing? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you like best about your child? \_\_\_\_\_

\_\_\_\_\_

VI. Behavioral Characteristics

Check any of the following that describe your child:

- |                          |                           |                    |
|--------------------------|---------------------------|--------------------|
| ____ Daydreams           | ____ Sleeps a lot         | ____ Loner         |
| ____ Stubborn            | ____ Suspicious           | ____ Secretive     |
| ____ Fearful             | ____ Perfectionist        | ____ Worries       |
| ____ Self-conscious      | ____ Jealous              | ____ Sensitive     |
| ____ Outgoing            | ____ Easily frustrated    | ____ Likeable      |
| ____ Teased by peers     | ____ Immature             | ____ Destructive   |
| ____ Aggressive          | ____ Threatens suicide    | ____ Steals        |
| ____ Bites fingernails   | ____ Nervous twitches     | ____ Apathetic     |
| ____ Whines a lot        | ____ Temper tantrums      | ____ Cruelty       |
| ____ Physical complaints | ____ Fears school         | ____ Tired         |
| ____ Overachieves        | ____ Underachieves        | ____ Swears        |
| ____ Moody               | ____ Sexually provocative | ____ Demanding     |
| ____ Alcohol, drug use   | ____ Bad friends          | ____ Strange ideas |

VII. Child's Medical History

Child is receiving special medical care or medications \_\_\_\_\_

\_\_\_\_\_

List any treatment or counseling for a specific condition (including speech or language therapy, medical treatment, psychotherapy, tutoring, etc.)

Agency or professional person	Dates(s)	Condition
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Explain any hospitalizations, illnesses or surgeries \_\_\_\_\_

\_\_\_\_\_

Explain any head injuries, loss of consciousness, or prolonged high fevers over 104 degrees \_\_\_\_\_

\_\_\_\_\_

When was child last seen by family physician or pediatrician \_\_\_\_\_

\_\_\_\_\_

VIII. Observations and Questions (continued)

List any specific questions you would like the evaluation or consultation to address.

Academic:

Emotional:

Behavioral:

Social:

Intellectual:

Additional Comments: