PARENTING ON CALL

CHILD & ADOLESCENT INTAKE FORM

Today's Date _____
Person completing this form _____
Who referred you to this practice? _____

PATIENT HISTORY
Child's Name _____ Gender _____
Date of Birth _____ Age _____

Parent Name (1) _____ Occupation _____
Address _____
Phone: Home _____ Work _____ Cell _____
Email: _____

Parent Name (2) _____ Occupation _____
Address _____
Phone: Home _____ Work _____ Cell _____
Email: _____

Marital Status of Parents _____
If divorced, what are the custody arrangements? _____
***Please include copy of custody agreement for the chart**

Please give other parent's address and phone number:
Name _____
Address _____
Phone: Home _____ Work _____ Cell _____
Please list name(s) of Stepparent(s) _____

Where was your child born and raised? _____
Has your child moved a number of times? Yes____ No____
If yes, please list their age at time of move and location: _____

List names of all people living in household (relationship to child and age)
_____
_____
_____
_____

List any siblings living outside the home (names and ages)
_____
_____
_____
Primary language spoken in the home _____

Other languages spoken _____
Briefly describe your concerns about your child.
_____

_____
_____
_____
_____
_____

Describe any current marital and/or family stress.

_____
_____
_____
_____

SCHOOL HISTORY

Current grade level: _____Current school:_____ Teacher's name: _____
School address: _____ Phone:_____ Fax: _____

Please list all schools attended, including preschool
School City State Grades Attended

_____
_____
_____
_____
_____

Please summarize child's progress (e.g., academic, social), within each of these grade levels:

Preschool:

Kindergarten:

Grades 1-3:

Grades 4-5:

Grades 6-8:

Grades 9-12:

What are your child's academic strengths?

_____

Academic weaknesses?

_____

Has there been a change in your child's performance at school? Yes _____ No _____

If yes, please describe: _____

Has your child received IQ or Academic testing? Yes _____ No _____

If yes, what were the results? _____

Does or has your child participated in any of the following?
Yes No Resource (for which classes/how many hours?)
Yes No Accelerated or Honors programs, explain:
Yes No Individual Education Plan (IEP), explain:
Yes No Virtual Academy, explain:
Yes No School Study Team (SST)
Yes No Speech and language therapy
Yes No Learning disabilities class
Yes No Behavioral/emotional disorders class

Has your child had problems with any of the following?
Yes No Truancy, explain:
Yes No Fights, explain:
Yes No Absenteeism, explain:
Yes No Detention, explain:
Yes No Suspension, explain: _____
Yes No School refusal, explain: _____
***Please bring copies of Psychological, Educational, Speech, Occupational Therapy Evaluations, if applicable**

AREAS OF CONCERN (check all that apply):

Personal/Social Adjustment:
( ) Unduly sad
( ) Overly anxious
( ) Overly aggressive
( ) Temper tantrums
( ) Withdrawn or shy
( ) Disturbing habits or mannerisms
( ) Strange or bizarre behavior
( ) Problems in peer relationships
( ) Drug or alcohol problems
( ) Problems with the law
( ) Harms self or others (suicidal or homicidal)
( ) Other (please specify):

School Adjustment:
( ) Academic problems
( ) Difficulty with peers
( ) Difficulty with authority
( ) Behavior problems
( ) Attendance problems or reluctance to go to school
( ) Learning disabilities
( ) Attentional problems
( ) Aches and pains related to school
( ) Other (please specify):

Family Adjustment:
( ) Parent-child problem
( ) Marital conflict or co-parenting problems
( ) Sibling conflict
( ) Recent family changes
( ) Neighborhood difficulties
( ) Mother experiencing difficulties
( ) Father experiencing difficulties
( ) Sibling experiencing difficulties
( ) Drug or alcohol problems in family
( ) History of trauma or loss
( ) Domestic violence ( ) Abuse ( ) Other (please specify):

Physical/Developmental Factors:
( ) Eating
( ) Sleeping
( ) Toileting
( ) Grooming
( ) Perceptual/visual functions
( ) Language or speech
( ) Motor coordination problems
( ) Other, (please specify):

Birth and Developmental History
Was your child adopted? _____ If yes, at what age _____
Was your child born full term or premature (if premature, note gestational age)? _____
Describe any complications with the pregnancy or birth (cord around neck, difficulty breathing, etc.)
_____
_____
_____

Birth Weight _____ Apgar scores, if known _____
Describe your child's infancy period, including temperament, difficulties with sleep, feeding, irritability
_____
_____
_____

Provide ages your child achieved the following developmental milestones
Sitting _____ Babbling _____
Crawling _____ First Words _____
Walking _____ Complete Sentences _____

Medical History
Describe any serious illnesses, surgeries, hospitalizations, or head injuries
_____
_____
Describe any allergies or chronic ear infections
_____
_____
When was your child's last vision and hearing checks, and what were the results?
_____
_____

Social-Emotional
Describe your child's temperament
_____
_____
What do you enjoy most about your child?
_____
_____
List your child's favorite activities
_____
_____
Describe your child's ability to get along with peers and adults, including authority figures
_____
_____
_____

Abuse History:
Has your child ever been the victim of abuse or neglect? Yes No

If yes, what was the nature of the abuse? (Please circle all that apply.)
Physical Emotional Neglect Accidents Disasters Sexual Witnessing violence Other:
Are you struggling with your marital relationship or parenting? Yes No
If yes, please describe:
_____

Has your child ever been involved with the following and if yes, please explain:
Yes No Child Protective Services
Yes No Children's Mental Health
Yes No Probation/Juvenile Probation/Detention
Yes No Boys and Girls Club or other mentorship program
Yes No Youth Services
Yes No Head Start
Yes No Early Intervention Services (ages 0-3)

TEEN/YOUNG ADULT SECTION

Do you have any concerns regarding your adolescent's friendships? Yes No
(Please circle all that apply.) Too old Too young Truant Gang Fringe Too much time together

Drug/alcohol use Violence Too many Too few Sexual Promiscuity Other

Has your adolescent had a recent change in friendships? Yes No If yes, what changes, if any are concerning to you? _____
_____

Are you concerned that your adolescent is using (or has used) drugs (including over the counter medicines) or alcohol? Yes No
If yes, please describe: _____
_____

Are you concerned about your child's sexual activities? Yes No

Is your adolescent sexually active? Yes No

Does your adolescent have a job? Yes No

Has your adolescent's behavior ever resulted in police, detention, or court involvement? Yes No
If yes, please explain: _____
_____

Is there anything else you would like us to know about your child?

Has your child ever seen a psychiatrist/psychotherapist before? If yes, please list: _____
_____

Previous history: Has he/she ever been treated for any of the following (check all that apply):

____ Depression	_____ADHD	____ Bipolar (Manic / Depressive) Disorder
____ Anxiety	_____OCD	____ Schizophrenia
____ Panic Attacks	_____PTSD	____ Alcohol Problems (including AA)
____Anorexia/ Bulimia	_____Binge-eating	_____ Drug Problems

(END TEEN/YOUNG ADULT SECTION)

Please list in chronological order all prior psychiatric hospitalizations (if any) below:

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Has he/she attempted to harm/kill themselves? If so, please list the occurrences below:

Approximate Date of Attempt	Method of Attempt

Please List *all* current medications below (include birth control pills, over the counter medication and herbal remedies (i.e., decongestants, St. John's Wort etc.)

Name of Medication	Dosage	How many times daily?	How long on medication?	Side Effects (if any)	Prescribing physician

Vestibular (Movements and Balance)

- ☐ Becomes overly excited after movement activity
- ☐ Thrill seeker on playground
- ☐ Avoids movement equipment on playground, prefers to play on:
- ☐ Seeks intense movement: spins, twirls, bounces, jumps, rocks
- ☐ Shakes head vigorously, assumes upside down position frequently
- ☐ Uncomfortable on elevators, escalators, motion sickness
- ☐ Excessive dizziness or nausea from swinging, spinning, riding in care
- ☐ Preoccupied with movement activities, can't sit still
- ☐ Avoids activities which require balance/losses balance easily
- ☐ As infant, tended to arch back when held or moved
- ☐ Trips easily, clumsiness
- ☐ Fear of heights, climbing, fear of falling when no real danger exists
- ☐ Hesitant when climbing or descending stairs (seeks hand, railing or walls)

Proprioceptive Functions

- ☐ Difficulty controlling movement uses to little or too much power/force
- ☐ Poor posture/postural instability
- ☐ Slumps in chair with rounded back and head forward and extended
- ☐ Pops head on hand or forearm
- ☐ Difficulty changing positions or moving slowly
- ☐ Craves tumbling or wrestling
- ☐ Frequently gives or requests firm or prolonged hugs
- ☐ Plays roughly with people or objects
- ☐ Bumps into things
- ☐ Leans on objects, people for stability
- ☐ Joints extremely flexible

Tactile Function

- ☐ Excessive reaction to light touch sensation (anxiety, hostility, aggression)
- ☐ As infant, not calmed by cuddling/stroking
- ☐ Difficulty standing in line or close to other people
- ☐ Stands too close to people to the point or irritation
- ☐ Tenses when patted affectionately
- ☐ Negative reaction to unseen, unexpected touch
- ☐ Clothes cover entire body, regardless of weather
- ☐ Wears minimal clothes, regardless of weather
- ☐ Avoids certain textures of clothing, materials
- ☐ Avoids putting hands in messy substances/getting dirty
- ☐ Engages in self-injurious behavior(s). List:
- ☐ Likes to be wrapped tightly in sheet or blanket, seeks tight spaces
- ☐ Engages in self-stimulatory behavior(s). List:
- ☐ Frequently adjusts clothing as if feeling uncomfortable
- ☐ Touches everything, can’t keep hands to self:
- ☐ No apparent response to being touched or bumped
- ☐ Avoids busy, unpredictable environments
- ☐ Extreme reaction to tickling
- ☐ Appears under/over sensitive to pain (circle if applicable)
- ☐ Socks must be just right: no wrinkles, twisted seems
- ☐ Picky eater. Prefers certain textures. List:
- ☐ Limits self to particular foods/temperatures. List:
- ☐ Avoids/seeks going barefoot on textured surfaces (grass, sand)

Auditory

- ☐ Overly sensitive to loud sounds or noises
- ☐ Covers ears to shut out auditory input
- ☐ Hears sound others don’t hear, or before others notice
- ☐ Sensitive to certain voice pitches
- ☐ “Tunes Out” or ignores sounds nearby
- ☐ Unable to pay attention when there are other sounds nearby
- ☐ Irrational fear of noisy applications
- ☐ Can only work with stereo/TV on
- ☐ Hums, sings softly, “self-tasks” through a task

- ☐ Voice volume too soft or too loud
- ☐ Seeks out toys, other objects which make sound. List:
- ☐ Craves music, other specific sounds
- ☐ Needs visual cue to respond to verbal commands or requests
- ☐ Mispronounces words (psghetti mazagine, etc.)
- ☐ Doesn't respond when name is called
- ☐ Appears not to hear what is said
- ☐ Frequently asks you to repeat what you have said
- ☐ Slow or delayed responses
- ☐ Difficulty sequencing the order of events when telling a story/describing an event
- ☐ Word finding difficulty
- ☐ Not precise in word selection
- ☐ Enjoys strange noises, makes repetitive sounds

Oculo-Motor Control & Visual Perception

- ☐ Poor depth perception, difficulty or hesitancy climbing or descending stairs
- ☐ Poor awareness of space in relation to things around self/gets lost easily
- ☐ Skips words/lines or loses place when reading
- ☐ Letter/number/word reversals
- ☐ Overly sensitive to lights/sunlight
- ☐ Poor eye contact
- ☐ Hypervigilant or visually distracted
- ☐ Writing illegible/misplaced on lines or page
- ☐ Dislikes/likes drawing
- ☐ Over stimulated by busy visual environment
- ☐ Keeps eyes too close to work
- ☐ Tilts head/props head/lays head on arm with desk work

Taste and Smell

- ☐ Highly sensitive to common odors or to faint odors unnoticed by other
- ☐ Does not seem to notice unpleasant smells
- ☐ Tends to overly focus on the taste or smell of non-food items
- ☐ Will not taste food prior to smelling it and approving of its smell
- ☐ Prefers bland foods/highly seasoned foods (Circle appropriate one)
- ☐ Hypersensitive to body odors suck as breath or scents of soap, perfume etc.

Fine Motor Skill

- ☐ Difficulty drawing, coloring, cutting
- ☐ Lines drawing are too light, wobbly, too dark, breaks pencil often (Circle appropriate)
- ☐ Poor handwriting in printing, cursive
- ☐ Lack of well-established hand dominance
- ☐ Difficulty using two hands together
- ☐ Prefers to eat with fingers
- ☐ Snaps/zippers/buttons are difficult/impossible to manage
- ☐ Immature grasp of tools such as pencil, fork, spoon, toothbrush
- ☐ Enjoys manipulative, puzzles, construction toys, coloring, drawing (Circle appropriate)

Self-Regulation

- ☐ Oversensitive, under sensitive, fluctuating sensitivity to stimuli
- ☐ Unusually high, low, fluctuating activity level
- ☐ Difficulty with transitions or change
- ☐ Difficulty modulating behavioral state

Emotional/Social Behavior

- ☐ Intense, explosive
- ☐ Easily frustrated, anxious
- ☐ Can't sit still, hyperactive
- ☐ Clingy, whiny, cries easily
- ☐ Stubborn, inflexible, uncooperative
- ☐ Poor self-concept/ low self-esteem
- ☐ Highly sensitive/can't take criticism
- ☐ Gives up easily
- ☐ Hard to awaken
- ☐ Hard to get to sleep
- ☐ Tantrums
- ☐ Fearful (list):
- ☐ Unable to adjust to changes in routine
- ☐ Slow to, or unable to make timely transitions
- ☐ Prefers company of adults to older children
- ☐ Prefers to play with younger children
- ☐ Easily discouraged or depressed
- ☐ Enjoys team sports
- ☐ Poor loser