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Intake Form - Child

Full Name:_____ Today's Date:_____

Age:_____ Birth Date:_____ Male or Female (Circle One)

Address:_____ City/State:_____

Zip:_____ Grade: _____ School:_____

Father_____ Phone:_____

Mother:_____ Phone:_____

Form Completed By:_____ Relationship to Client: Parent Custodial Parent Guardian

Family Status/Living Situation: Single Parent Two Parent Grandparent Adoptive Parents Joint Custody

Please check all applicable options and add comments as needed

I. Questions Regarding Overall Health:

Date of last physical:_____

Do you suffer from any of the following?

A. Sleep

___Difficulty Falling Asleep or Staying Asleep
___Difficulty Waking
___Restless Sleep
___Sleepwalking/Night terrors/Nightmares
___Bruxism (Grinding teeth)

B. Auditory/Olfactory

___Ringing in the Ears
___Hearing Loss
___Ear aches
___Decrease in Sense of Smell

C. Visual

___Double Vision
___Vision Problems/Blurred Vision
___Blind Spots

Clinician's Notes

Onset:

Duration:

Length:

Quality:

Dreams:

D. Other

___Allergies
___Asthma
___Frequent illness
___Fatigue
___Chronic pain

Clinician's Notes

E. Cardiovascular / Pulmonary

___Heart Problems ___Breathing Problems ___Palpitations or Tachycardia ___Hypertension

Clinician's Notes

F. Dermatological

___Skin Problems_____

_____

G. Endocrine/Gastrointestinal

___Hot/ Cold Sensitivity
___Excessive Thirst
___Appetite Awareness
___Thyroid Disorder
___Stomach Pain
___Chronic Constipation
___Intestinal Pain
___Nausea/Vomiting
___Enuresis (Uncontrolled Peeing)
___Encopresis (Uncontrolled Pooping)

Clinician's Notes

H. Neurological

___Headaches ___Fainting ___Tremor or Spasticity
___Coordination ___Speech Problems ___Accident Prone
___Weakness ___Balance ___Over-active
___Motor or Vocal Tics ___Seizures ___Under-active

Clinician's Notes

I. Attention and Organization

___Attention Span ___Distractibility ___Impulsivity ___Organizational Ability

Clinician's Notes

J. Habits (Please indicate both past and present participation)

Dietary Habits _____

Sugar Intake_____

Caffeine Intake_____

K. Behavior/Emotions

___Mood Swings
___Panic Attacks
___Manic-Depression
___Anxiety
___Irritability
___Eating Disorders
___Depression
___Anger/Aggression
___Addictions
___Fears/Phobias
___Tantrums/Violent Behavior
___Risk-Taking Behavior
___Obsessive Compulsive Symptoms

Clinician's Notes

L. School Behavior and Performance

___Math	Excels	Average	Difficulty
___Spatial Skills	Excels	Average	Difficulty
___Art	Excels	Average	Difficulty
___Verbal Expression	Excels	Average	Difficulty
___Writing	Excels	Average	Difficulty
___Memory	Excels	Average	Difficulty
___Reading	Excels	Average	Difficulty

Favorite Subjects (Strengths)_____

Least Favorite Subjects (Weaknesses)_____

Teacher Complaints_____

Clinician's Notes

M. Home Behavior

___Problems with Parents_____

___Problems with Siblings_____

Clinician's Notes

II. Personal History

A. Perinatal

___Prenatal Stress or Injury
___Difficult Birth
___Adopted at age ___
___Prenatal Drug Exposure
___Premature or Late Birth
___Difficult Labor
___Medical Problems after Birth

B. Growth and Development

___Colic
___Activity Level
___Motor Development
___Chronic Ear Infections
___Sleep Problems
___Attachment
___Allergies
___Asthma
___Eating Problems
___Emotional Development
___Language Development

C. Physical Traumas

___Head Injury
___Serious Illness
___Poisoning
___Accidents
___CNS Infection
___Anoxia
___Extreme Fever
___Drug Overdose

D. Psychological Traumas and Stresses

___Abuse or Neglect ___Family Stress __School Stress ___Death in Family ___Illness

E. Spiritual (Please be as specific as possible, estimating frequency of involvement)

___Prayer ___Fasting ___Meditation ___Bible/Wisdom Literature Reading ___Other

Denominational Affiliation:_____

Clinician's Notes

Treatment History

Medications: (Use backside if more room is needed)

Medication	For Condition	Dose	Dates

Medical Treatment:

Procedure	For Condition	Physician Address/Phone	Dates

Psychological Therapy:

Therapy	For Condition	Therapist Address/Phone	Dates

Other Therapy:

Therapy	For Condition	Therapist Address/Phone	Dates

Family History

Symptom	Yes	No	Relationship to You
Asthma			
Autoimmune Disorders: Type 1 Diabetes, Rheumatoid Arthritis, Lupus, MS, Scelorderma, etc.			
Migraine			
Sleep Problems			
Depression			
Manic-Depression			
Anxiety			
Phobias			
Panic Attacks			
Motor or Vocal Tics			
Eating Disorders or Obesity			
Addictions			
Obsessive Compulsive Symptoms			
Speech Problems			
Attention Problems			
Learning Problems			
Conduct Problems or Criminal			
Behavior			
Autism Spectrum			
Schizophrenia			