History/Intake Form

Welcome to our practice. The purpose of this form is to gather some important background information, as well as information about your primary concerns. This form, like all of the information you provide in our practice, is private and confidential. Please complete this form as fully as possible. If you have any questions, please contact us, or make a note of your question and we will be happy to discuss it during our intake meeting.

Date: _____

Patient's Name: _____ Date of Birth: _____

Person(s) completing this form: _____

Relationship to patient: _____

REFERRAL INFORMATION

Who referred you to this office, or how did you learn of this practice?

_____

_____

Please describe the main problems or concerns that have caused you to seek an assessment?

_____

_____

_____

_____

_____

When did you first notice these concerns (age and/or grade)?

_____

_____

_____

Have you consulted others, or attempted other interventions for these concerns? Have these interventions been helpful?

_____

_____

_____

FAMILY AND BACKGROUND INFORMATION

Parent Information

Parent Name: _____ Age:_____ Education: _____
Employment: _____ Relationship to patient: _____

Parent Name: _____ Age:_____ Education: _____
Employment: _____ Relationship to patient: _____

Are parent(s): _____ Married _____ Single _____ Separated _____ Divorced _____ Widowed

If married, how long married?_____
If separated/divorced, how long? _____
If widowed, how long? _____
Is either parent remarried, and if so, how long? _____
Has either parent been married in the past? _____

Did/does either parent have concerns similar to the referral concerns, or did/does either parent have difficulties with attention, learning, mood/anxiety difficulties, other psychiatric/medical disorders (e.g., seizures or other neurological disease or disorder) or substance abuse? If yes, please describe:

_____
_____
_____
_____

If applicable, please complete the following section for step-parents, legal guardians, or other caregiving adults:

Name: _____ Age:_____ Relationship to child: _____
If other adult does not reside with the child, please provide the following:
Address: _____
City: _____ State: _____ Zip: _____
Phone number(s): _____ (h) _____ (w) _____(c)

Name: _____ Age:_____ Relationship to child: _____
If other adult does not reside with the child, please provide the following:
Address: _____
City: _____ State: _____ Zip: _____
Phone number(s): _____ (h) _____ (w) _____(c)

Sibling Information

Siblings residing in the patient's primary home:
Name and Age: _____ Name and Age: _____

Name and Age: _____ Name and Age: _____

Siblings not residing in the patient's primary home:

Name and Age: _____ Name and Age: _____

Name and Age: _____ Name and Age: _____

Did/does any sibling have concerns similar to the referral concerns, or did/does any sibling have difficulties with attention, learning, mood/anxiety difficulties, other psychiatric/medical disorders (e.g., seizures or other neurological disease or disorder) or substance abuse? If yes, please describe:

_____
_____
_____
_____

Other Individuals residing in the primary home:

Name and Age: _____ Relationship to patient:_____

Name and Age: _____ Relationship to patient:_____

Name and Age: _____ Relationship to patient:_____

Did/does any extended family member (aunts, uncles, cousins, etc) have concerns similar to the referral concerns, or did/does any extended family member (aunts, uncles, cousins, etc) have difficulties with attention, learning, mood/anxiety difficulties, other psychiatric/medical disorders (e.g., seizures or other neurological disease or disorder) or substance abuse? If yes, please describe:

_____
_____
_____
_____

BIRTH, EARLY DEVELOPMENT AND MEDICAL HISTORY

Is the referred patient adopted? _____ Y _____ N
If yes, please briefly describe the circumstances of adoption (e.g., open adoption, closed adoption, international or domestic adoption, etc.)

_____
_____
_____
_____

Pregnancy and Birth History

Was prenatal care available and accessed during the pregnancy? _____
Did mother smoke during pregnancy? ___Y ___ N (Please describe frequency/amount: _____)
Drink alcohol? ___Y ___ N (Please describe frequency/amount: _____)
Use other drugs or medications? ___Y ___ N (Please describe type/frequency/amount: _____)

Were there any medical concerns associated with this pregnancy (e.g., toxemia or elevated blood pressure, unusual bleeding, unusual illness/exposure, excessive morning sickness, injury, severe emotional distress)? If yes, please explain

_____
_____
_____

Was labor spontaneous or induced? _____
Did labor occur at full term, premature, or later than expected? _____
If premature or late, at what week did labor begin? _____
Length of labor? _____ Pain medication used? ___Y ___ N
Complications during labor? _____

Was delivery vaginal or caeserean? _____
Were there any complications during delivery, and if so, please describe (e.g., breech delivery, compromised airway, etc.) _____
_____
_____

Birth weight?: _____
General birth status (e.g., healthy, jaundice, use of oxygen, etc): _____
Was the patient admitted to the neonatal intensive care unit for monitoring/care? If yes, please explain:

_____
_____

Were there any difficulties with early feeding and/or sleeping?

_____
_____

How would you describe the patient's early temperament and behavior (e.g., easy to soothe, irritable, good sleeper, calm, fussy, etc)?

_____
_____

Early Developmental/Medical History:
At what age did patient:
Walk alone _____
Say first word _____
Become toilet trained: _____ (_____ daytime _____ nighttime)

Were there any early difficulties with these or other developmental milestones and behaviors? If early difficulties were present, did you discuss these with a professional and/or seek assessment or intervention?

_____
_____
_____

Is/Was the patient monitored by a pediatrician or primary care physician? If so, please list their name and/or contact information:

_____

Is/Was the patient seen regularly by any other physicians/specialists? If yes, please list name and contact information:

_____

_____

Does/Has the patient have/had any of the following:

_____ Measles	_____ Ear Infections	_____ Allergy/Asthma
_____ Whooping Cough	_____ Tubes in ears	_____ Head Injuries
_____ Mumps	_____ Seizures/Convulsions	_____ Meningitis
_____ High fever	_____ Hearing problems	_____ Vision problems

_____ Other Medical condition: _____

Is this patient currently on any medications? If yes, please list name, dosage, and prescribing physician:

_____

_____

Has the patient ever received therapy/counseling? When and with whom?

_____

_____

Has the patient ever had a psychological/psychoeducational evaluation in the past? If yes, please provide name, approximate date, and/or provide a copy of the report:

_____

_____

Does this patient have a history of being the victim of physical or sexual abuse, or neglect? If yes, please provide additional information about the history, any Social Services involvement, and follow-up care:

_____

_____

_____

Does this patient have a history of being the victim of, or being a witness to domestic violence? If yes, please provide additional information about the history, any Social Services involvement, and follow-up care:

_____

_____

_____

Does this patient have a history of being exposed to any other traumatic experience (e.g., severe car accident, fire, etc)? If yes, please provide additional information about the history, and follow-up care:

_____

_____

_____

Has this patient ever been hospitalized or admitted to a residential program?

_____

_____

ACADEMIC HISTORY

Current School:_____ Grade Level? _____
Address: _____
City: _____ State: _____ Zip: _____
Phone number(s): _____ Contact Person: _____
Academic Performance: ____ Poor ____ Fair ____ Good; Behavioral ____ Poor ____ Fair ____ Good

Previous Schools:
Name: _____ Dates: _____
Academic Performance: ____ Poor ____ Fair ____ Good; Behavioral ____ Poor ____ Fair ____ Good

Name: _____ Dates: _____
Academic Performance: ____ Poor ____ Fair ____ Good; Behavioral ____ Poor ____ Fair ____ Good

Name: _____ Dates: _____
Academic Performance: ____ Poor ____ Fair ____ Good; Behavioral ____ Poor ____ Fair ____ Good

Has the patient ever been retained or skipped a grade? If so, when? _____

Were there any years when he/she did better than currently or worse than currently? When and why was that?

_____
_____

Please briefly describe the typical homework process for this patient (e.g., scheduled at a specific time of day or varies, can be done without supervision or needs assistance, compliant or resistant with homework).

_____
_____

Has the patient been referred for and/or received special education services? If yes, please explain:

_____
_____

Has the patient received informal accommodations? If yes, please explain:

_____
_____

Has the patient ever, or is the patient now, participating in a tutoring program? If yes, please provide name, dates, and contact information if available:

_____
_____

Has there been a history of behavioral difficulties in school, including peer conflict, teacher conflict, truancy, suspension or expulsion? If yes, please explain:

_____
_____

SOCIAL AND INTERPERSONAL INFORMATION

How does the patient get along with family members (immediate and/or extended)?

How does the patient get along with other adults in positions of authority (e.g., teachers)?

How does the patient get along with peers?

What type of activities/hobbies/clubs does the patient participate in?

How would you describe the patient's daily/typical mood?

Have you noticed a change in mood and/or activities in the last 6 months to a year?

Has this patient experienced any of the following, either now or in the past:

Auditory Hallucinations	_____Y ____N	Visual Hallucinations	____Y ____N
Suicidal thoughts	_____Y ____N	Suicide attempts	____Y ____N
Homicidal thoughts	_____Y ____N		

ADDITIONAL INFORMATION

Is there any information that has not been asked, that you feel we should know?

Thank you.