3200 Tower Oaks Blvd., Suite 200 Rockville, MD 20852 Phone: 301-593-6554 Fax: 301-255-0461
11161 New Hampshire Ave., Suite 307 Silver Spring, MD 20904 Phone: 301-593-6554 Fax: 301-754-1034

CHILD/ ADOLESCENT INTAKE

DEVELOPMENTAL AND SOCIAL HISTORY QUESTIONNAIRE

Date:______________________ Form Completed by:______________________________________

PATIENT / FAMILY INFORMATION

Child/Adolescent Name: ____

Address: ____

____

Date of birth: ______________________ School: __________________________ Grade: __________

Pediatrician: __________________________ Referred by: __________________________________

Parent/Guardian's Name:	Parent/Guardian's Name:
______________________________	______________________________
Relationship: ______________________	Relationship: ______________________
Occupation: ______________________	Occupation: ______________________
Home Address:	Home Address:
______________________________ (if different from above)	______________________________ (if different from above)
______________________________	______________________________
Phone (home): ______________________	Phone (home): ______________________
Phone (work): ______________________	Phone (work): ______________________
Phone (cell):______________________	Phone (cell):______________________
Email:______________________	Email:______________________

Parent's Marital Status: __________________________ If not married, date of divorce: __________________

Legal custody of children*: ____

****PLEASE PROVIDE A COPY OF SEPARATION/DIVORCE DOCUMENTS PERTAINING TO CUSTODY.***

Are there other relatives or adults that are important caretakers for your child (i.e. stepparent, significant other, grandparent, nanny)? Please list.

Name	Relationship	Phone

Child’s brothers or sisters below (please include stepsiblings)

Name	Relationship	Age

If your child is adopted, indicate age at time of adoption and country of birth:

DEVELOPMENT

PREGNANCY AND DELIVERY

Problems during pregnancy? ____

Problems during delivery? ____

INFANCY

Any illness during newborn period? ______________________________

Were there: ☐ Feeding problems ☐ Excessive vomiting ☐ Crying ☐ Colic ☐ Diarrhea

Other complications during first year?

DEVELOPMENTAL MILESTONES

Approximate age at which

Child walked alone ____________________ Spoke in simple sentences _____________

Toilet Trained: Bladder _________________ Bowel _________________________

Does child have bladder control? ___________ Bowel control? ____________________

Accidents during the day ☐ Yes ☐ No? If so, how often?

MEDICAL HISTORY

Any illness other than normal childhood diseases?

☐ allergies ☐ chronic ear infections ☐ frequent colds

☐ head injuries ☐ Convulsions/seizures ☐ eye problems

Operations/hospitalizations ____

If child is on medications, indicate reason, type and dosage.

HABITS (If child exhibits any of the following, please check and describe briefly.)

☐ Temper tantrums

☐ Low frustration tolerance

☐ Problems when parents leave

☐ Fears

☐ Clumsiness

☐ Poor self-esteem

☐ Sleep problems, nightmares

☐ Destructiveness

☐ Frequent mood changes

☐ Slurred speech

☐ Alcohol/substance abuse

☐ More active than siblings

☐ Interrupts frequently

☐ Excessive number of accidents

☐ Poor handwriting

☐ Poor memory

☐ Short attention span

☐ Stealing, lying

☐ Fighting

☐ Irritability

☐ Facial or other tics

☐ Interrupts frequently

Describe any checked above:

SCHOOL HISTORY

Rate your child's school experience related to ACADEMIC LEARNING:

Nursery School	☐ Good	☐ Average	☐ Poor
Elementary School	☐ Good	☐ Average	☐ Poor
Middle School	☐ Good	☐ Average	☐ Poor
Current Grade	☐ Good	☐ Average	☐ Poor

To the best of your knowledge, at what grade level is your child functioning?

___________ Reading ___________ Spelling ___________ Math

Has your child ever had to repeat a grade? ☐Yes ☐No If so, when? ______________________________

Present class placement: ☐ Regular class ☐ Special class or resources

If so, specify:____

Rate your child's school experience related to BEHAVIOR:

Nursery School	☐ Good	☐ Average	☐ Poor
Elementary School	☐ Good	☐ Average	☐ Poor
Middle School	☐ Good	☐ Average	☐ Poor
Current Grade	☐ Good	☐ Average	☐ Poor

Does your child's teacher describe any of the following or significant classroom problems?

☐ Doesn't sit still in his/her seat

☐ Frequently gets up and walks around the classroom

☐ Shouts out; doesn't wait to be called upon

☐ Does not cooperate in group activities

☐ Typically does better in a one-to-one relationship

Describe briefly any other classroom behavioral problems:

CHILDCARE

Who cares for this child when the parents are gone? ____

How many hours per day is this child in a child-care setting? ______________________________________

Before school care? ☐ Yes ☐ No After school care? ☐ Yes ☐ No

FAMILY

How does your child get along with each parent?

Is this child closer to one parent than the other?

Has this child ever experienced any parental separations, divorces, or death?

☐ Yes ☐ No If yes, when? ________________ How old was child at the time? _______________

Please describe the circumstances.

How often does the child see each parent and what is the schedule?

FAMILY HISTORY

Describe any psychiatric problems, drug abuse, or alcoholism in immediate family and extended family:

Have either parent or any of the blood relatives had a problem similar to the child's? ☐ Yes ☐ No

If so, please describe:

FRIENDS

Does your child seek friendships with peers? ____

Is your child sought by others for friendship?____

Does your child play primarily with children his/her own age? ______________________________________

Younger? ☐ Yes ☐ No Older? ☐ Yes ☐ No

What role does your child usually take in peer group games or activities (for example, bossy, leader, aggressive, passive, etc.)?

INTERESTS AND ACCOMPLISHMENTS

What are your child's main interest and hobbies?

What are your child's strengths and areas of greatest accomplishments?

MAJOR AREAS OF CONCERN

What is child's problem and when did it begin?

How have you tried to resolve the problem? What have you found to be effective?

Has your child been treated for this problem before? ____
By whom? ________________________________ Results

Has child had any psychological testing in the school or privately conducted?

ADDITIONAL REMARKS: Please use the remainder of this page as well as the back to write any additional comments you wish to make regarding your child's difficulties.