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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: _____

Parents 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?

- | | | |
|--|---|---|
| <input type="checkbox"/> allergies | <input type="checkbox"/> chronic ear infections | <input type="checkbox"/> frequent colds |
| <input type="checkbox"/> head injuries | <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> 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.)

- | | |
|--|--|
| <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> More active than siblings |
| <input type="checkbox"/> Low frustration tolerance | <input type="checkbox"/> Interrupts frequently |
| <input type="checkbox"/> Problems when parents leave | <input type="checkbox"/> Excessive number of accidents |
| <input type="checkbox"/> Fears | <input type="checkbox"/> Poor handwriting |
| <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Poor self-esteem | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Sleep problems, nightmares | <input type="checkbox"/> Stealing, lying |
| <input type="checkbox"/> Destructiveness | <input type="checkbox"/> Fighting |
| <input type="checkbox"/> Frequent mood changes | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Slurred speech | <input type="checkbox"/> Facial or other tics |
| <input type="checkbox"/> Alcohol/substance abuse | <input type="checkbox"/> Interrupts frequently |

Describe any checked above:

SCHOOL HISTORY

Rate your child's school experience related to ACADEMIC LEARNING (select one response):

- | | | | |
|-------------------|-------------------------------|----------------------------------|-------------------------------|
| Nursery School | <input type="checkbox"/> Good | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |
| Elementary School | <input type="checkbox"/> Good | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |
| Middle School | <input type="checkbox"/> Good | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |
| Current Grade | <input type="checkbox"/> Good | <input type="checkbox"/> Average | <input type="checkbox"/> 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 special, specify: _____

Rate your child's school experience related to BEHAVIOR (select one response):

- | | | | |
|-------------------|-------------------------------|----------------------------------|-------------------------------|
| Nursery School | <input type="checkbox"/> Good | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |
| Elementary School | <input type="checkbox"/> Good | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |
| Middle School | <input type="checkbox"/> Good | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |
| Current Grade | <input type="checkbox"/> Good | <input type="checkbox"/> Average | <input type="checkbox"/> 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? _____

Please describe the circumstances.

How old was child at the time? _____

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:

Has 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 children? Yes No Older children? 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.