Alvord | Baker & Associates, LLC

3200 Tower Oaks Blvd., Suite 200 Rockville, MD 20852 Phone: 301-593-6554 Fax: 301-255-0461
8401 Connecticut Ave., Suite 1120, Chevy Chase, MD 20815 Phone: 301-593-6554 Fax: 301-754-1034

Child/Adolescent Intake & Developmental History

Date:_____ Form Completed by:_____

PATIENT/FAMILY INFORMATION

Child/Adolescent Name: _____

Address: _____

_____

Date of birth:_____School:_____Grade:_____

Pediatrician:_____Referred by: _____

Parent/Guardian's Name:

_____

Relationship:_____

Occupation:_____

Home Address: (if different from above)

_____

_____

Phone (home): _____

Phone (work): _____

Phone (cell):_____

Email:_____

Parent/Guardian's Name:

_____

Relationship:_____

Occupation:_____

Home Address: (if different from above)

_____

_____

Phone (home): _____

Phone (work): _____

Phone (cell):_____

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 or delivery? _____

INFANCY

Any illness during newborn period? _____

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

Other complications during the 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	☐ More active than siblings
☐ Low frustration tolerance	☐ Interrupts frequently
☐ Problems when parents leave	☐ Excessive number of accidents
☐ Fears	☐ Poor handwriting
☐ Clumsiness	☐ Poor memory
☐ Poor self-esteem	☐ Short attention span
☐ Sleep problems, nightmares	☐ Stealing, lying
☐ Destructiveness	☐ Fighting
☐ Frequent mood changes	☐ Irritability
☐ Slurred speech	☐ Facial or other tics
☐ Alcohol/substance abuse	☐ Interrupts frequently

Describe any checked above:

SCHOOL HISTORY

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

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 (please specify):

_____

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

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? _____

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.