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# History-Intake Form

**Identifying Information:**

<table>
<tr><td colspan="2">Child's Name:</td><td colspan="3">Date of Birth: Age:</td></tr>
<tr><td colspan="2">Address:</td><td>City:</td><td>State:</td><td>Zip Code:</td></tr>
<tr><td colspan="2">Mother's Name:</td><td colspan="3">Father's Name:</td></tr>
<tr><td>Home Phone:</td><td>Work Phone:<br>Mother:<br>Father:</td><td colspan="3">Cell Phone:<br>Mother:<br>Father:</td></tr>
<tr><td colspan="5">Email:</td></tr>
</table>

**Payment Information (please check one):**

| Insurance Company: | Policy #: |
|---|---|
| Policy holder: | Policy Holder's Date of Birth (needed for Blue Cross billing): |

**Who referred you?:**

| Name: | Connection to Patient: |
|---|---|
| Agency (if applicable): | Phone #: |

**Brief Problem Description:**

<table>
<tr><td colspan="4">What is your main question or concern? (Also, please see page 8)</td></tr>
<tr><td colspan="4">What have you been told by doctors, teachers and/or others about your child's problem?</td></tr>
<tr><td>Has your child been given a diagnosis?<br>☐ Yes ☐ No</td><td>When?</td><td>By Whom?</td><td>What diagnosis?</td></tr>
</table>

***IMPORTANT: PLEASE SEND COPIES OF MOST RECENT EVALUATIONS, REPORTS AND EDUCATIONAL PLANS (IEPs, 504 Plans) WITH THIS FORM.**

**Family Information:**

| Name | Relationship to child | Occupation/School Grade: | Living with the patient? |
|---|---|---|---|
| | | | Yes ☐ No ☐ |
| | | | Yes ☐ No ☐ |
| | | | Yes ☐ No ☐ |
| | | | Yes ☐ No ☐ |
| | | | Yes ☐ No ☐ |
| | | | Yes ☐ No ☐ |
| Please check marital status:<br>☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Unmarried/Living Together | | | |
| If separated or divorced, with whom is child living?<br>Who has custody? | | | |

**Family Medical History:**

| Please identify any of the child's biological relatives (brother, sister, parent, uncle, aunt, cousin, grandparent, etc.) who have had any of the following conditions. | | |
|---|---|---|
| Condition: | Relationship to child: (father, sister, aunt, etc.) | Please elaborate: |
| ☐ Attention Problems/ Hyperactivity | | |
| ☐ School Difficulties/ Learning Disabilities | | |
| ☐ Psychiatric or Emotional Problems (e.g., Depression, Anxiety) | | |
| ☐ Autism/PDD Asperger's syndrome | | |
| ☐ Communication/ Language Problems | | |
| ☐ Social Disabilities | | |
| ☐ Alcoholism/ Substance Abuse | | |
| ☐ Mental Retardation | | |
| ☐ Seizure Disorder | | |
| ☐ Other (describe): | | |
| Does your child remind you of any of the above noted relatives? ☐ Yes ☐ No<br>Please elaborate: | | |

**Pregnancy & Birth History:**

| During pregnancy, did mother: | | | | | |
|---|---|---|---|---|---|
| Drink alcohol? | ☐ Yes | ☐ No | Take any drugs? | ☐ Yes | ☐ No |
| Smoke cigarettes? | ☐ Yes | ☐ No | Take any medications? | ☐ Yes | ☐ No |
| Birth was: Normal ☐ | Cesarean ☐ | Breech ☐ | Multiple Births ☐ | | |
| Birth weight: | Full term? ☐ Yes ☐ No If premature, how many weeks early? | | | | |
| Were there any complications? ☐ Yes ☐ No<br>If yes, please specify: | | | | | |

**Early Developmental History:**

| Were there any problems in the first year of life? ☐ Yes ☐ No<br>If yes, please specify: |
|---|

During the first 12 months, was this child:

| | | | | | |
|---|---|---|---|---|---|
| Difficult to feed? | ☐ Yes | ☐ No | Easy to comfort? | ☐ Yes | ☐ No |
| Difficult to get to sleep? | ☐ Yes | ☐ No | Alert? | ☐ Yes | ☐ No |
| Difficult to put on a schedule? | ☐ Yes | ☐ No | Cheerful? | ☐ Yes | ☐ No |
| Colicky? | ☐ Yes | ☐ No | Affectionate? | ☐ Yes | ☐ No |
| Overactive/in constant motion? | ☐ Yes | ☐ No | Sociable? | ☐ Yes | ☐ No |

| How old was child when (s)he: | Age | If not sure of age, please estimate if: | | |
|---|---|---|---|---|
| Walked: | | Early ☐ | Average ☐ | Late ☐ |
| Said first words: | | Early ☐ | Average ☐ | Late ☐ |
| Began using sentences: | | Early ☐ | Average ☐ | Late ☐ |
| Toilet trained: | | Early ☐ | Average ☐ | Late ☐ |

Has s(he) ever had:

| | | | | | |
|---|---|---|---|---|---|
| Chronic ear infections | ☐ Yes | ☐ No | Lead poisoning | ☐ Yes | ☐ No |
| Seizures | ☐ Yes | ☐ No | Head injury or concussion | ☐ Yes | ☐ No |
| Has s(he) ever had any serious illness or hospitalization?<br>(If yes, please describe:) | | | | ☐ Yes | ☐ No |

**Medical Information:**

| | |
|---|---|
| Name of Pediatrician/PCP:<br>Address: | Telephone #: |
| Is this child generally in good health? ☐ Yes ☐ No (If no, please describe:) | |
| Does this child have any allergies? ☐ Yes ☐ No (If yes, to what?) | |
| If child is taking any medications currently, please list:<br>1. Medication:____________________<br>2. Medication: | <br>Reason:____________________<br>Reason: |
| If child is seeing any other specialists, please list:<br>1. Specialist:____________________<br>2. Specialist: | <br>Reason:____________________<br>Reason: |

**Educational Information:**

| Name of Current School: | Grade: | Telephone #: |
|---|---|---|
| Address: | Name of teacher or contact: | |
| Has (s)he ever repeated a grade?<br>☐ Yes ☐ No If yes, which grade: | Is there an IEP? ☐ 504 plan? ☐<br>Are you appealing it?: ☐ Yes ☐ No | |
| Has (s)he ever received any special/extra help in school? ☐ Yes ☐ No | Is (s)he *currently* receiving any special/extra help in school?: ☐ Yes ☐ No | |

If yes, please check off type of services received:

| Reading ☐ | Resource Room ☐ | In-class help ☐ | Separate class ☐ | Aide ☐ |
|---|---|---|---|---|
| Occupational Tx ☐ | Physical Tx ☐ | Speech/Language Tx ☐ | Counseling ☐ | |
| Other (specify): | | | | |
| Has (s)he ever had a developmental, psychological, neuropsychological or educational (CORE)evaluation? ☐ Yes ☐ No If yes, when?: Where?: | | | | |
| Have you requested or is your child scheduled to be tested through the school in the near future (e.g., CORE evaluation)? ☐ Yes ☐ No If scheduled, when? | | | | |

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**Vision:**

| Does your child have: | |
|---|---|
| Trouble seeing at a distance? ☐ Yes ☐ No | Wear glasses for distance? ☐ Yes ☐ No |
| Trouble seeing up close? ☐ Yes ☐ No | Wear glasses for reading? ☐ Yes ☐ No |
| Ever been to an eye doctor? ☐ Yes ☐ No | Most recent date: |

**Language and Speech:**

| What is child's main language(s):<br>What is parents' main language(s):<br>What is child's primary way of communicating? Talking ☐ Signs ☐ Gestures ☐ |
|---|
| Does your child have any: Hearing problems? ☐ Yes ☐ No |
| Has (s) ever had an Audiology evaluation? ☐ Yes ☐ No<br>If yes, when? What were the results? |
| Does (s)he have any problems understanding what is said to him/her? ☐ Yes ☐ No |
| Does (s)he have any speech problems/difficulty speaking? ☐ Yes ☐ No |
| Has (s)he ever had a Speech & Language evaluation? ☐ Yes ☐ No<br>If yes, when? What were the results? |
| Has (s)he received Speech & Language therapy: Currently? ☐ In the past? ☐<br>If yes, where? |
| Please elaborate on any problems/concerns in this area: |

**Fine Motor Skills:**

| Does your child have any **fine motor** problems (writing, drawing, etc.)? ☐ Yes ☐ No<br>Specify: |
|---|
| Has (s)he ever had an Occupational Therapy (OT) evaluation? ☐ Yes ☐ No<br>If yes, when? What were the results? |
| Has (s)he received OT services: Currently? ☐ In the past? ☐<br>If yes, where? |
| Please elaborate on any problems/concerns in this area: |

**Gross Motor Skills:**

| Does your child have any **gross motor** problems (walking, running, bike riding etc.)?<br>☐ Yes ☐ No Specify: |
|---|
| Does your child use any special equipment (wheel chair, braces, etc..)? ☐ Yes ☐ No<br>**Specify:** |
| Has (s)he ever had an Physical Therapy (PT) evaluation? ☐ Yes ☐ No<br>If yes, when? What were the results? |
| Has (s)he received PT services: Currently? ☐ In the past? ☐<br>If yes, where? |
| Please elaborate on any problems/concerns in this area: |

**Behavior/Mental Health:**

| Does your child receive any mental health services (therapy, counseling)? ☐ Yes ☐ No<br>If yes, Therapist: __________________Agency: ______________ Phone #: ___________<br>Reason: |
|---|
| Is there any DSS involvement? No ☐ Yes: Now ☐ In the past ☐ |

**Do you feel your child has/had any of the following symptoms/problems *more than is typical for his/her age*?**

| | | |
|---|---|---|
| Often defies adult rules:<br>Currently ☐<br>In the past ☐ | Often bullies/threatens:<br>Currently ☐<br>In the past ☐ | Overreacts to noise or touch:<br>Currently ☐<br>In the past ☐ |
| Often angry/resentful:<br>Currently ☐<br>In the past ☐ | Initiates physical fights:<br>Currently ☐<br>In the past ☐ | Poor social interactions:<br>Currently ☐<br>In the past ☐ |
| Often argues with adults:<br>Currently ☐<br>In the past ☐ | Often truant from school:<br>Currently ☐<br>In the past ☐ | Extreme mood swings:<br>Currently ☐<br>In the past ☐ |
| Often loses temper:<br>Currently ☐<br>In the past ☐ | Cruel to animals:<br>Currently ☐<br>In the past ☐ | Often irritable:<br>Currently ☐<br>In the past ☐ |
| Blames others for mistakes:<br>Currently ☐<br>In the past ☐ | Destroys property:<br>Currently ☐<br>In the past ☐ | Depressed mood:<br>Currently ☐<br>In the past ☐ |
| Refuses to go to school:<br>Currently ☐<br>In the past ☐ | Deliberately sets fires:<br>Currently ☐<br>In the past ☐ | Often sad/cries easily:<br>Currently ☐<br>In the past ☐ |
| Frequent nightmares:<br>Currently ☐<br>In the past ☐ | Difficulty keeping friends:<br>Currently ☐<br>In the past ☐ | Sleep problems:<br>Currently ☐<br>In the past ☐ |
| Excessive anxiety:<br>Currently ☐<br>In the past ☐ | Lies often:<br>Currently ☐<br>In the past ☐ | Thinks about death:<br>Currently ☐<br>In the past ☐ |
| Panic attacks/unusual fears:<br>Currently ☐<br>In the past ☐ | Steals:<br>Currently ☐<br>In the past ☐ | Thinks or talks about suicide:<br>Currently ☐<br>In the past ☐ |
| Somatic complaints (headaches, stomachaches):<br>Currently ☐<br>In the past ☐ | Excessive preoccupations with ideas or objects:<br>Currently ☐<br>In the past ☐ | Self-injurious behaviors:<br>Currently ☐<br>In the past ☐ |
| Repeats certain actions:<br>Currently ☐<br>In the past ☐ | Strange or bizarre ideas:<br>Currently ☐<br>In the past ☐ | Uses alcohol/drugs:<br>Currently ☐<br>In the past ☐ |
| Can't stop thinking about things:<br>Currently ☐<br>In the past ☐ | Gets upset by changes in routine:<br>Currently ☐<br>In the past ☐ | Motor or vocal tics:<br>Currently ☐<br>In the past ☐ |

**Please place a check mark in the column that best describes your child:**

| | Not at all | Just a little | Pretty much | Very much |
|---|---|---|---|---|
| 1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities. | | | | |
| 2. Often has difficulties sustaining attention in tasks or play activities. | | | | |
| 3. Often does not seem to listen when spoken to. | | | | |
| 4. Often does not follow through on instructions and fails to finish schoolwork or chores (not due to oppositional behavior or failure to understand instructions). | | | | |
| 5. Often has difficulty organizing tasks and activities. | | | | |
| 6. Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as homework). | | | | |
| 7. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books or tools). | | | | |
| 8. Is often easily distracted by extraneous stimuli. | | | | |
| 9. Is often forgetful in daily activities. | | | | |
| 10. Often fidgets with hands or feet, or squirms in seat. | | | | |
| 11. Often leaves seat in classroom or other situations in which remaining seated is expected (e.g., dinner table). | | | | |
| 12. Often runs about or climbs excessively in situations where it is inappropriate (in adolescents or adults may be limited to subjective feelings of restlessness). | | | | |
| 13. Often has excessive difficulty playing or engaging in leisure activities quietly. | | | | |
| 14. Is often “on the go” or acts as if “driven by a motor.” | | | | |
| 15. Often talks excessively. | | | | |
| 16. Often blurts out answers before questions have been completed. | | | | |
| 17. Often has difficulty waiting turn. | | | | |
| 18. Often interrupts or intrudes on others (e.g., butts into conversation or games). | | | | |

In your own words, please describe your concerns, and add any additional information that you feel is important and may be helpful in our assessment:

What **specific** questions do you have that you hope an evaluation will answer?

| Signature of person completing this form: | Relationship to child: | Date: |
| --- | --- | --- |
| | | |

*IMPORTANT: If your child is taking medication for attention problems (ADD, ADHD), please call prior to the testing appointment to discuss whether (s)he should take the medication the day of the appointment.*