



Comprehensive Intake Questionnaire for Child Evaluations – Ages 6-9

This questionnaire will help me best understand your child and his/her current difficulties.

Child's information

Date: _____

Name of child: _____

Date of Birth: _____ **Age:** _____

Name of person filling out form and relationship: _____

Home address: _____

Mother: _____ (H) _____ (W) _____ (C)

Father: _____ (H) _____ (W) _____ (C)

Family Email(s): _____

Child's School: _____

Child's Current Grade: _____

Current learning and/or psychiatric diagnoses: _____

Who diagnosed: _____

Known genetic disorders or medical diagnoses: _____

Is your child taking any medications at this time? If yes, list all medications, current dosages and length of time your child has been on the medication.

Name of Current Medication(s)	Dosage	Date Started
1.		
2.		
3.		
4.		

What problems or questions have caused you to seek help for your child at this time?

Family History

Child is living with:

_____ Both parents _____ Mother _____ Father _____ Legal Guardian

_____ Other (specify) _____

Status of parent's marriage: (If divorced, consent must be given by both parents for assessment.)

_____ Married (how long? _____ years)
 _____ Separated (child's age at separation _____ years)
 _____ Divorced (child's age at divorce _____ years)
 _____ Single _____ Widowed

If parents are divorced, please indicate whether there are stepparents:

_____ Stepmother _____ Stepfather

Is your child adopted?

_____ No _____ Yes (if yes, age at adoption _____)

Please complete the following information regarding biological parents in the appropriate column:

Please provide relevant information:

	Mother	Father
Age		
Highest Level of Education Completed		
Degrees/Diplomas		
Current Occupation		
Describe any special education or tutoring received		
Describe grades repeated or subject areas that were difficult.		
Any diagnosed learning difficulties? If so in what subjects?		
Any psychological or psychiatric problem for which treatment was received?		
Any Attention Deficit Disorder (with or without Hyperactivity?)		

Please provide relevant information:

	Adoptive Mother/Stepmother	Adoptive Father/Stepfather
Age		
Highest Grade Completed		
Occupation		

Please list other children in the family (including step-siblings and half-siblings):

Name	Gender	Age	In home?	Social/Behavioral/Health Problems

Biological extended family

Do any extended family (grandparents, uncles, aunts, cousins) suffer from any of the following: inattentiveness or hyperactivity, behavior problems, learning difficulties, epilepsy, seizures, migraines, alcoholism/drug abuse, psychological, emotional or personality difficulties, depression or bipolar disorder, schizophrenia, developmental disabilities, Autism or Aspergers disorder, anxiety or “nervousness”, congenital abnormalities, other neurological conditions etc.? If so, please list the relationship to your child, the disorder and any treatment received:

Maternal (Mother’s Side)

Paternal (Father’s Side)

Please provide any additional information about your child’s extended family that might help me understand your child’s needs (medical, behavioral, psychological, educational, and emotional):

Pregnancy and Birth

Pregnancy with this child: Length of pregnancy _____ weeks

Any of the following complications during pregnancy with this child (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Difficulty in Conception | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Abnormal Weight Gain | <input type="checkbox"/> German Measles |
| <input type="checkbox"/> Excessive Vomiting | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Excessive Swelling | <input type="checkbox"/> Flu |
| <input type="checkbox"/> Vaginal Bleeding | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Other (e.g. Rh incompatibility) |
| <input type="checkbox"/> Toxemia | <input type="checkbox"/> Hospitalization during pregnancy |

Has this child ever received Occupational Therapy?

_____ No _____ Yes (details _____)

Has this child ever received Physical Therapy?

_____ No _____ Yes (details _____)

At what age did this child toilet train?

_____ days _____ nights

Did bed-wetting and/or bed soiling occur after training?

_____ No _____ Yes (until what age _____)

Has this child every received speech and/or language therapy?

_____ No _____ Yes (details _____)

Is your child left or right handed? _____

Does your child wear a hearing aid? _____ No _____ Yes

Does your child wear glasses/contact lenses? _____ No _____ Yes

Did any event, health condition, separation etc. disturb infant/parent bonding or the developing toddler/parent relationship?

_____ No _____ Yes (details _____)

Infancy and Early childhood

Please rate this child on the following behaviors. Check 1 if the behavior on the left was present the majority of the time and check 5 if the behavior on the right was present the majority on the time. Stages in between are represented by 2, 3, and 4.

Quiet and content	1	2	3	4	5	Colicky and irritable
Very easy to feed	1	2	3	4	5	Daily feeding problems
Slept well	1	2	3	4	5	Daily/frequent sleeping problems
Usually relaxed	1	2	3	4	5	Often restless
Underactive	1	2	3	4	5	Overactive
Cuddly, easy to hold	1	2	3	4	5	Did not enjoy cuddling
Easily calmed down	1	2	3	4	5	Tantrums and/or head banging
Cautious and careful	1	2	3	4	5	Accident prone and/or daredevil
Coordinated	1	2	3	4	5	Uncoordinated
Enjoyed eye contact	1	2	3	4	5	Avoided eye contact
Liked People	1	2	3	4	5	Disliked contact with people

Other comments/problems regarding infancy or early childhood development (use other side if needed):

Who is your child's pediatrician? (No information will be released or obtained without your written permission.)

Name _____ Office Phone Number _____

Has your child ever had a psychiatric or neurological examination?

_____ No _____ Yes (details _____)

If your child is currently under psychiatric or neurological care, please give the name, address and phone number of the treating physician. (No information will be released or obtained without your written permission.)

Name _____ Office Phone Number _____

What time does your child go to bed? _____

What time does your child get up? _____

Does your child have a consistent bedtime routine? _____ No _____ Yes

Are you concerned that your child does not get enough sleep and/or has poor sleep quality? _____ No _____ Yes

Medical History

Please circle if any of the following are applicable to your child.

Measles	Whooping Cough	Broken bones
German Measles	Scarlet Fever	Asthma
Mumps	Head Injury	Sinus condition
Chicken Pox	Coma or loss of consciousness	Surgery
Tuberculosis	Sustained high fever	_____
Rheumatic Fever	Any fever above 104 degrees	Allergies to food
Diphtheria	Anemia	Allergies to medicine
Meningitis		Environmental allergies
Encephalitis		

Respiratory Conditions

Frequent Colds
Chronic Cough
Asthma
Hay Fever
Sinus Condition

Genitourinary Concerns

Urination in pants/bed
Pain while urination
Excessive urination
Strong odor to urine

Cardiovascular Conditions

Shortness of breath with exertion
Dizziness with exertion
Heart condition
Heart Murmur

Musculoskeletal Concerns

Muscle Pain
Clumsy Walk
Poor posture
Other muscle problems

Gastrointestinal Conditions

Excessive Vomiting
Frequent Diarrhea
Constipation
Stomach Pain

Skin Concerns

Frequent rashes
Bruises easily
Sores
Severe Acne
Eczema

Neurological Concerns

- Seizures/convulsions
- Speech defects
- Accident-prone
- Sucks thumb
- Grinds teeth
- Bites nails
- Picks skin
- Tics/Twitches

- Bangs head
- Rocks back and forth
- Unusual body movements

Speech Concerns

- Stuttering
- Unclear speech
- Other speech problems

Please also list any medication taken by your child in the past for longer than 3 months duration:

Educational History

Please identify all preschools/daycares and schools your child has attended giving dates of attendance in sequential order.

Name of Preschool/Daycare/School	From (date)	To (date)	# Days/Week	# Hours/Day

Does your child like going to school? (if applicable) _____ No _____ Yes

Has your child ever been retained a grade in school? _____ No _____ Yes

Has your child ever skipped a grade in school? _____ No _____ Yes

Has your child had difficulty with reading? _____ No _____ Yes

Has your child had difficulty with math? _____ No _____ Yes

Has your child had difficulty with writing/spelling? _____ No _____ Yes

**Do you have concerns about the quality of your child’s school and/or teachers?
_____ No _____ Yes**

Has your child ever had psycho-educational testing either by your school district, special school district or by a private practitioner? _____ No _____ Yes

**Is your child currently receiving any special education services?
_____ No _____ Yes (If yes, please bring copies of IEP or 504 plan.)**

**Does your child receive any private tutoring outside of his/her regular school schedule?
_____ No _____ Yes (details _____)**

**Has your child taken any standardized achievement tests at school? (e.g. MAP/ERB/SAT/ACT)
_____ No _____ Yes (If yes, please bring copies of the results.)**

Describe what you hear from your child's teachers about your child's experience at pre-school.

Social Interactions

Which of the following best describes the way your child is related to by other children?

- a. My child is very popular with his/her peers.
- b. My child is neither popular nor unpopular with his/her peers.
- c. My child is unpopular with his/her peers.

Which best describes the role your child takes with peer interactions:

- a. My child likes to be the leader most of the time.
- b. My child prefers to follow other kids.
- c. My child can flexible; taking the role of either the leader or the follower depending on the situation.

The following table is designed to assess your child's ability to relate to other children.

	Yes	No
Does your child have difficulty relating to other children?		
Does your child physically fight a lot with other children?		
Does your child argue a lot with other children?		
Does your child prefer playing with younger children?		
Does your child have difficulty making friends?		
Does your child have difficulty maintaining friendships?		
Does your child have a best friend?		
Is your child invited to other children's houses for play dates?		
Is your child invited to birthday parties as often as you think he/she should be?		
Are there children in your neighborhood with whom your child can play?		
Does your child prefer to play alone?		
Does your child have difficulty with the non-verbal rules of social interaction? (e.g. turn taking, how close to stand to others)		

Any other comments about your child's interactions with other children? _____

Is your child enrolled in any extracurricular activities or hobbies? (e.g. team or individual sports, music lessons, karate, boy/girl scouts, etc.) Please list:

Describe your child's use of screens (TV, Gaming, Computers)

____ Less than 1 hr/day ____ 2-4 hrs/day
____ 1-2 hrs/day ____ More than 4 hrs/day

Does your child have a cell phone? ____ No ____ Yes

Does your child have social networking access (e.g. Facebook)? ____ No ____ Yes

Please circle the traits/characteristics below, which apply to your child now:

Happy	Tantrums	Withholding of affection
Sad	Lethargic	Thoughtful
Moody	Requires a lot of parental attention	Dreamer
Friendly	Too responsible	Difficulty calming down
Quiet	Even-tempered	Cooperative
Overactive	Short attention span	Withdrawn
Independent	Impulsive	Easily over-stimulated
Dependent	Angry	Curious
Sensitive	Lacking in self control	Imaginative
Affectionate	Explosive	Good sense of humor
Fearful	Volatile	
Overreacts		

Other words you would use to describe your child: _____

Please describe any major family or parental stressors that may have impacted your child in the past or that may impact him or her now:

Are there any particularly traumatic or troubling events which have happened in this child's life which I should know about in order to understand him/her better? (Please give details, including incidents you feel were traumatic for this particular child, though they might not have been for another child)

Has your child ever witnessed violence inside or outside of the home?

____ No ____ Yes (details _____
_____)

Has your child ever had psychological counseling or therapy?

____ No ____ Yes (details _____
_____)

Please list the names, addresses, and telephone numbers of any other professionals consulted. (This does not give me permission to contact them, and they will only be contacted with your written consent.)

Is there any additional information or anything that you feel is pertinent to know regarding your child that has not been covered in this questionnaire?

What changes do you hope will result from seeking counseling?