CrossRoads Counseling Centers

Comprehensive Intake Questionnaire for Child Evaluations - Preschool

This questionnaire will aid in understanding 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):

_____
_____
_____

<u>Pregnancy and Birth</u>
Pregnancy with this child: Length of pregnancy _____ weeks

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

_____Difficulty in Conception
_____Abnormal Weight Gain
_____Excessive Vomiting
_____Excessive Swelling
_____Vaginal Bleeding
_____Anemia
_____Toxemia
_____Measles
_____German Measles
_____Emotional Problems
_____Flu
_____High Blood Pressure
_____Other (e.g. Rh incompatibility)
_____Hospitalization during pregnancy
_____Maternal Injury
_____X-Rays during pregnancy (what month? _____)
_____Medication during pregnancy (what?_____)
_____Alcohol during pregnancy (frequency_____)

_____Cigarettes during pregnancy (frequency_____)
_____Other drugs during pregnancy (type and frequency_____)
_____ Drugs while trying to conceive (mother – what? _____)
_____ Drugs while trying to conceive (father – what? _____)

Birth:
Mother's age at birth of child _____ years
Father's age at birth of child _____years
Was child born in a hospital? _____Yes _____No
Length of Labor: _____ hours
Child's Birth Weight: _____lbs. _____ozs.
Apgar Scores: _____
Child's condition at birth: _____

Check the relevant birth details:
____ Vaginal delivery
____ Caesarean Section
____ Forceps used
____ Breech Birth
____ Induced Labor
____ Delivery complications (describe _____)
____ Incubator needed
____ Jaundiced (If yes, Bilirubin lights? _____Yes _____No)
____ Breathing problems right after birth (describe_____)
____ Supplemental oxygen (how long needed_____)
____ Birth defects (explain_____)
____ NICU stay (details_____)

Do you think this child's difficulties might be related to pregnancy, labor or delivery?
_____No ____Yes (details_____

_____)

Did this child have frequent ear infections as an infant? _____No _____ Yes
If yes, did this child have ear tubes inserted surgically? _____No _____ Yes

Gross Motor, Fine Motor, and Language Milestones
At what age did this child first do the following (in months)? If you don't remember exactly, but recall no concerns, you can write WNL (within normal limits)

_____ Turned Over
_____ Sat Alone
_____ Crawled
_____ Stood Alone
_____ Walked Alone
_____ Fed self with spoon
_____ Scribbled
_____ Understood first words
_____ Spoke first words
_____ Spoke in sentences

Did your child have difficulty learning how to do any of the following (circle all that apply):

Ride a bike Throw and/or catch a ball

Skip Hop Jump

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

Respiratory Conditions
Frequent Colds
Chronic Cough
Asthma
Hay Fever
Sinus Condition

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

Gastrointestinal Conditions
Excessive Vomiting
Frequent Diarrhea
Constipation
Stomach Pain

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

Musculoskeletal Concerns
Muscle Pain
Clumsy Walk
Poor posture
Other muscle problems

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

Do you have concerns about the quality of your child's school and/or teachers?
_____No _____Yes

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

_____

_____

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

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

____ 1-2 hrs/day

____ 2-4 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	Dreamer
Friendly	attention	Difficulty calming down
Quiet	Too responsible	Cooperative
Overactive	Even-tempered	Withdrawn
Independent	Short attention span	Easily over-stimulated
Dependent	Impulsive	Curious
Sensitive	Angry	Imaginative
Affectionate	Lacking in self control	Good sense of humor
Fearful	Explosive	
Overreacts	Volatile	

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?