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CHILD INTAKE INFORMATION FORM

Please bring this completed questionnaire with you to your first appointment.

Child's Name: _____D.O.B.: _____Age: _____
Last First

Home Address: _____
Street City State Zip Code

Home/Cell Phone: _____ Email (*Optional):_____
**By providing your email you are offering permission for information to be exchanged between the email recipient and this office.*

Child's School: _____
Name Address Grade

Biological Parents:

Parent's Name: _____ Relationship: _____
Business Name: _____ Business Phone: _____
Can we call you at work if necessary? Yes: _____ No: _____

Parent's Name: _____ Relationship: _____
Business Name: _____ Business Phone: _____
Can we call you at work if necessary? Yes: _____ No: _____

Permission to Provide Professional Services to my Child: We generally need both biological parents' permission for your child to receive professional services from our office, unless we have copies of a legal document indicating otherwise. If you are living together, we typically give you one Child Intake Information Form to complete. You should both provide permission for your child to receive professional services from our office by signing below. If you are separated, we will give you two Child Intake Information Forms to complete, and you should both provide permission for your child to receive professional services from our office through your signature on the Child Intake Information Form you receive. Either or both parents can obtain copies of our records of their child, unless we have copies of a legal document indicating otherwise. Through my signature below, I give Dr. Bloodgood permission to provide professional services to my child.

_____ _____
Parent's Signature Parent's Signature

_____ _____
Date Date

Other adults involved with child (Use reverse side of page if necessary)
Name: _____ Relation: _____
Home/Cell Phone: _____ Business Phone: _____

Person we can call if we cannot reach you in an emergency:

Name: _____ Relation: _____
Home/Cell Phone: _____ Business Phone: _____

Who referred you to our office? _____

Problems Seeking Consultation For:
1._____

2._____

3._____

Current Stressor/Triggers That "Cause" these Problems:
1._____

2._____

3._____

Pregnancy:
- Complications: _____
- Alcohol consumption during pregnancy: _____ Amount: _____ Smoking consumption during pregnancy: _____ Amount: _____
- Medications taken during pregnancy: _____
- X-Ray studies during pregnancy: _____ Duration of pregnancy in weeks: _____

Delivery:
- Complications: _____
- Infant injured during delivery? (If Yes, Specify Type): _____

Post Delivery Period (While in Hospital):
- Birth Weight: _____ Total number of days child was in the hospital: _____
- Respiration: Immediate: _____ Delayed (If So, How Long?): _____
- Cry: Immediate: _____ Delayed (If So, How Long?): _____
- Cyanonsis (Turned Blue): _____ Incubator Care? _____ Number of Days: _____
- Sucking: Strong: _____ Weak:_____
- Infections (Specify): _____
- Birth Defects (Specify): _____

Infancy/Toddler Period: Where any of the following present, to a significant degree, during the first few years of life? If so please describe.
- Did not enjoy cuddling: _____
- Was not calmed by being held and/or stroked: _____
- Excessively restless: _____
- Diminished sleep because of restlessness and easy arousal: _____
- Frequent head banging, hand flapping, hang wringing: _____ _____
- Constantly into everything: _____
- Excessive number of accidents compared to other children: _____

When Did Your Child Reach The Following Developmental Milestones?

Developmental Milestone	Age	Early	Normal Time	Late	Comments
Smiled					
Sat Without Support					
Crawled					
Stood Without Support					
Walked Without Assistance					
Spoke First Words Besides "Ma-Ma, Da-Da"					
Said Phrase					
Said Sentences					
Bowel Trained-Day					
Bowel Trained-Night					
Bladder Trained-Day					
Bladder Trained-Night					
Rode Tricycle					
Rode Bike Without Training Wheels					
Buttoned Clothing					
Tied Shoelaces					
Named Colors					
Said Alphabet in Order					
Began To Read					

Rate Your Child's Coordination in The Following Areas:

	Good	Average	Poor
Walking			
Running			
Throwing			
Catching			
Shoelace Tying			
Buttoning			
Writing			
Athletic Abilities			

Comprehension and Understanding:

Do you consider your child to understand directions and situations as well as other children his or her own age?

Yes _____ No (Specify): _____

Intellectual Ability:

How would you rate your child's intelligence compared to other children? (Circle One)

Below average Average Above Average

School:

Rate your child's school experience according to ***Academic Learning***:

Pre-School	Good	Average	Poor
Kindergarten	Good	Average	Poor
Elementary School	Good	Average	Poor
Middle School	Good	Average	Poor
High School	Good	Average	Poor

To the best of your knowledge, what grade level is your child functioning in the following areas?

Arithmetic_____ Writing_____ Reading_____ English_____

Has your child ever had to repeat a grade, if so what grade and when: _____

Present class placement: _____

Kinds of special therapy or remedial work your child is currently receiving: _____
_____

Describe briefly any academic problems: _____
_____

Rate your child's school experience according to ***Behavior:***

Pre-School	Good	Average	Poor
Kindergarten	Good	Average	Poor
Elementary School	Good	Average	Poor
Middle School	Good	Average	Poor
High School	Good	Average	Poor

Please check any of the following classroom problems your child's teacher describes as significant:

- ☐ 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
- ☐ Won't wait his or her turn
- ☐ Does not cooperate well in group activities
- ☐ Typically relates better in a one-to-one relationship
- ☐ Doesn't respect the rights of others
- ☐ Doesn't pay attention to story telling

Describe briefly any other behavior classroom behavioral problems: _____
_____

Peer Relationships: Please check if the statement applies to your child.

- ☐ Your child seeks friendships with peers
- ☐ Peers seek friendships with your child
- ☐ Your child plays primarily with children of his/he own age

Describe briefly any problems your child may have with peers: _____
_____

Interests and Accomplishments:

What are your child's interests, hobbies, and enjoyments? _____

What are your child's greatest accomplishments? _____
What does your child like doing least? _____

Medical History: If your child's medial history includes any of the following, please note the age when the incident or illness occurred and other pertinent information.
Childhood diseases: (Describe any complications): _____
_____
Operations: _____
Hospitalizations for illnesses other than hospitalizations: _____
_____
Head injuries: _____
With unconsciousness_____ Without unconsciousness_____
Convulsions: _____ With fever: _____ Without fever: _____
Coma: _____
Meningitis or Encephalitis: _____
Immunization Reactions: _____
Persistent High Fevers: _____ Highest fever: _____ Problems
With: Vision/ Eyes: _____ Hearing/ Ears: _____
Speech/ Dental: _____ Dermatology: _____
Poisoning: _____
Processing concerns: Auditory, visual: _____

Present Medical Status:
Present height: _____ Present weight: _____
Present illness for which child is being treated: _____
_____
Medications child is taking: _____
_____

Trauma History:
Has your child been exposed to/ or involved in a traumatic event (physical abuse, verbal abuse, emotional abuse, sexual abuse), Please describe? _____
_____

Family History:
Biological Mother: Current age: _____ Age at time of pregnancy with child: _____
School: Highest Grade completed: _____
Past or current psychological problems (Specify): _____
Learning disorders (Specify): _____
Behavioral problems (Specify) _____
Substance use: _____
Medical problems: _____
Any blood relatives with psychological, learning, behavioral, or substance use problems? (Specify): _____
_____

Biological Father: Current age: _____
School: Highest Grade completed: _____
Past or current psychological problems (Specify): _____
Learning disorders (Specify): _____
Behavioral problems (Specify) _____
Substance use: _____
Medical problems: _____

Any blood relatives with psychological, learning, behavioral, or substance use problems? (Specify): _____
_____

Siblings:
Please list name and current age of all siblings including half-sibling and step-sibling:
_____
_____
_____

Family Dynamics: Please check all that apply:

- ☐ Child lives with both biological parents
- ☐ Child's parents are divorced

  Custody agreement exists: Custody agreement for visitation (Specify):_____
  Age of child when divorce occurred: _____

Other Professionals Consulted Regarding Child's Problems:

Name of Professional	Title/Role	Phone	Address

1._____

2._____

3._____

4._____

Please use this space to provide any additional information pertaining you your concern with your child's difficulties:
_____
_____
_____
_____

Thank you for answering these questions. Your answers are most valuable in understanding your child. I look forward to seeing you.