Note: All information provided on this form will be part of your child's confidential file.

I General Information:

Child's Name		Today's Date _____ / _____ / _____
Address		
City	State	Zip Code
Phone	Cell Phone	Birth Date _____ / _____ / _____
Person completing this form		Relationship to child
Language(s) spoken in the home		

Is there any other language spoken to the child during the day? [ ] Yes [ ]No

By whom?

What are your main concerns regarding your child that you would like to be addressed in psychotherapy?

II Family History:

Mother's Name		Mother's Age
Mother's Address		
City	State	Zip Code
Phone	Cell Phone	
Highest level of Education		Occupation

Father's Name		Father's Age
Father's Address		
City	State	Zip Code
Phone	Cell Phone	
Highest level of Education		Occupation

Brothers and Sisters:

Name	Age	Sex	Grade	Mental Health Issues and/or Medical Issues

Have you or anyone else in your family not listed above experienced any mental health issues?

Relationship	Mental Health Issue

III Birth History:

During this pregnancy or delivery, did mother experience any unusual illness, condition, or accident such as German measles, Rh incompatibility, special medical care, false labor, etc.?
[ ] Yes [ ] No
If Yes, please describe:

Length of pregnancy: _____ Birth Weight: ____ lbs ____ oz
Birth was: [ ] Normal [ ] Caesarean [ ] Breech [ ] Multiple Birth
Was your child in the Neonatal Intensive Care Unit (NICU)? [ ] Yes [ ] No
If Yes, how long: _____

Please check those conditions that applied to your child immediately following birth:

[ ] Difficulty breathing	[ ] Sucking problems	[ ] Seizures
[ ] Blue skin	[ ] Swallowing difficulties	[ ] Scars and bruises
[ ] Jaundice	[ ] Feeding problems	[ ] Cord wrapped around neck
[ ] Genetic disorder	[ ] Meningitis	

Please describe any unusual events or problems during the first year:

IV Developmental:

At what age did the following occur?

Held up his / her head: __ yr ___ mo	Sat alone without support: __ yr ___ mo
Pulled up to a standing position: __ yr ___ mo	Walked unaided: __ yr ___ mo
Bladder trained: __ yr ___ mo	Bowel trained: __ yr ___ mo
Completely toilet trained: __ yr ___ mo	

Check if your child:

[ ] Prefers right hand	[ ] Shows awkwardness in using his / her hands	[ ] Prefers left hand
[ ] Has difficulty eating	[ ] Falls or loses balance easily	[ ] Has difficulty swallowing

Compared to other children your child's age, describe how your child is able to sit, stand, run, use his / her hands:

_____

_____

_____

V Health History:

Present weight: _____ lbs Present height: _____ ft _____ in

Check any illnesses that your child has had:

[ ] Measles	[ ] Scarlet Fever	[ ] Bronchitis	[ ] Chicken Pox
[ ] Croup	[ ] High Fever(s)	[ ] Mumps	[ ] Tonsillitis
[ ] Laryngitis	[ ] Asthma	[ ] Frequent flu cases	[ ] Allergies

[ ] Ear Infection(s), Were tubes inserted? [ ] Yes [ ] No, If Yes, when: _____

[ ] Other, Please describe: _____

Check any of the following diagnoses that apply to your child:

[ ] Cleft Lip and/or Palate	[ ] Attention Deficit Disorder	[ ] Central Auditory
[ ] Tourette's Syndrome	[ ] Hyperactivity Disorder	[ ] Seizure Disorder
[ ] Down Syndrome	[ ] Pierre Robin Sequence	[ ] Hearing Loss
[ ] Developmental Delays	[ ] Pervasive Developmental	[ ] Autism Disorder
[ ] Language Learning Disability	[ ] Attention Deficit Processing Disorder	

[ ] Other, Please describe: _____

Is your child taking any medications regularly? [ ] Yes [ ] No

If Yes, specify: _____

Did your child ever require hospitalization? [ ] Yes [ ] No

If Yes, indicate the illness, child's age at admission, and the length of the stay:

_____

_____

_____

Pediatrician or Family Physician Phone

VI Pre-school History:

Does your child attend a pre-school or daycare program? [ ] Yes [ ]No

If Yes, how often? _____

When did he / she start in pre-school program? _____ / _____ / _____

Has the teacher ever expressed any concerns about your child? [ ] Yes [ ] No

If Yes, what were the concerns? _____

How does your child get along with others at pre-school? _____

Any other comments about your child at pre-school?

_____

_____

VII School History:

_____

School now attending Grade Teacher's Name

_____

School Address

City State Zip Code

What are your child's average grades? _____
Strongest subjects: _____
Weakest subjects: _____
Has your child's teacher(s) expressed any concern about your child? [ ] Yes [ ] No
If Yes, what were the concerns? _____
How does your child get along with the others at school? _____
Does your child have a current IEP (Individualized Educational Program)? [ ] Yes [ ] No
If Yes, please list pertinent staff working with you: _____
Please explain any concerns regarding your child's school performance:

IX Other Therapy and Evaluations:

Has your child ever been in any type of therapy (e.g., psychotherapy, speech therapy, occupational therapy)? [ ] Yes [ ] No
If Yes, how old was your child? _____ yr
Was therapy helpful? [ ] Yes [ ] No
Why or why not? _____

Has your child ever had any psychological testing done in the past? [ ] Yes [ ] No
If Yes, when and where? _____
What were the results? _____

Has your child ever had a neurological evaluation? [ ] Yes [ ] No
If Yes, when and where? _____
What were the results? _____

Has your child had a recent medical examination? [ ] Yes [ ] No
If Yes, when and where? _____
What were the results? _____

X Additional Information:

Are you concerned about any behavioral problems? [ ] Yes [ ] No
If Yes, describe:

In your own words, describe your child's personality:

If there is additional information that might help us to understand your child and his / her communication better, please describe: