Children's Neuropsychological Services, PLLC
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CHILD INTAKE FORM

GENERAL INFORMATION

Child's (patient's) Name:____ Age:________________

Date of Birth (DOB):__________________________ Grade:_______________

Child's sex at birth: ____________ Gender: _____________ Preferred Pronouns: ____________

Parent/Guardian's Name:____ Today's Date:______________

Address:____
Street City/Town State Zip Code

Primary phone:________________________________Other phone:_______________________________

Email: ____

Spouse or Partner's Name (if applicable): ____

PRESENTING CONCERNS

What are your main concerns about this child?

At what age was this child's problem first noted? By whom?

What do you hope to get out of this evaluation or treatment?

HEALTH & MENTAL HEALTH INFORMATION

Primary care physician: ____

Were there any complications with the mother's pregnancy or the child's birth?

Were there problems with multiple ear infections or fluid? ______ Were PE tubes placed? ______

Any problems with hearing? ______ Please describe ____

Any problems with vision? ______ Does this child wear glasses? ____________________________

____ near sighted _____ far sighted _____astigmatisms

Does your child currently have any medical problems? Describe:

Please list current prescription medications with dosage (general health and psychiatric):

Does or did your child have any developmental problems (speech, fine motor, gross motor, language)?

My child is: ______right handed ______left-handed ______ambidextrous

Has your child ever been treated for any of the following (Put an "X" next to all that apply)?

_____ Head Injury _____ High fevers _____ Strokes _____ Cancer

_____ Diabetes/Kidney _____ Seizures _____ Allergies _____Neurologic conditions

_____ Fainting _____ Headaches _____Loss of consciousness

_____ Other condition(s) ____

Has your child previously seen a psychologist or psychiatrist? ________ If so, when? _______________

Who did your child see? ___________________________ Reason? _______________________________

Has your child ever been hospitalized for medical or mental illness? _______ List when, where, & reason:

Are any of the following current problems for your child (Put an "X" next to all that apply)?

_____ Depression _____ School problems _____ Motor Tics _____ Legal problems

_____ Vocal tics _____ Anxiety _____ Social difficulties _____ Sleep problems

_____ Eating disorder _____ Trauma _____ Alcohol/Substance abuse

Have you or your child experienced any unusually severe stressors during the last year? If yes, please describe:

INTERESTS/ACTIVITIES/SCHOOL

What are some of your child's interests & activities?

What do you consider to be your child's personal strengths and/or talents ?

Current School:________________________________District_________________________________

Has your child been evaluated for learning disability at school? ______ If so, when?_______________

Does your child have an IEP? _____________ Since when? _________________________________

Does your child have a 504 plan? __________ Since when? _________________________________

What kind of class/school does your child attend?

_____Regular Classes _____Integrated _____Self-Contained ______Home schooled

Describe academic weaknesses/deficits:

Describe academic strengths:

FAMILY HISTORY

Please indicate if any members of your family and extended family has a history of the following (Put an "X" next to all that apply). Please also indicate the family member's relationship to your child.

		List Family Member(s) Relationship to Your Child
learning disorder	_____	________________________________
attention deficit/hyperactivity disorder	_____	________________________________
tic disorder/Tourette syndrome	_____	________________________________
anxiety (general)	_____	________________________________
phobias	_____	________________________________
panic attacks	_____	________________________________
obsessive compulsive behaviors	_____	________________________________
depression	_____	________________________________
bipolar/manic depressive	_____	________________________________
anger control problem	_____	________________________________
substance abuse	_____	________________________________
eating disorder	_____	________________________________
other ________________________________	_____	________________________________

Is there any other information you would like to add?