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IDENTIFYING INFORMATION: Date:_____

Name of Child: _____
Home Address:
_____
_____

Cell phone #: _____
Email: _____
D.O.B./Age: _____
Gender Identity/Pronoun Preference:
_____
School/current grade: _____

Pediatrician - Name and Address:
_____
Mothers Name:
_____
Address (if different than child's):
_____
Home phone #: _____ **Cell:** _____
Email: _____
Occupation: _____
Father's Name:
_____
Address (if different than child's):
_____
Home phone #: _____ **Cell:** _____
Email: _____
Occupation: _____

Please list the names, ages, and dates of birth of the client's (your child's) siblings.

Name(s)	Age(s)	Date(s) of Birth

WHO REFERRED YOU?/REASONS FOR REFERRAL:

- Primary concerns:

- Other concerns:

- What do you hope to get from treatment?

- What are your Child's ideas about therapy? what have they been told about the process?

PRENATAL HISTORY:

1. Were there any complications or problems during pregnancy or delivery?

2. Was this a planned pregnancy?

3. Were any of the following taken during pregnancy: beer, wine, alcohol, prescription medications, herbal medicines/supplements not prescribed by a physician?

4. Were there any complications after the pregnancy?

5. Was your child in the NICU after delivery?

6. Was your child adopted? If so, what were the circumstances around the adoption?

7. Was your child concieved via:

IVF:_____ Surrogate:_____

POSTNATAL PERIOD AND INFANCY:

1. Were there early infancy feeding problems?

2. Was the child colicky?

3. Were there early infancy sleep pattern difficulties? Where did the baby sleep?

4. Were there any problems with the infant's responsiveness/alertness?

5. Did the child experience any health problems during infancy?

6. How active was your child as an infant?

DEVELOPMENTAL MILESTONES:

At what age did your child:

1. Sit up _____
2. Crawl _____
3. Walk _____
4. Speak single words _____
5. String together 2 or more words _____
6. Toilet train (Bladder) _____ (day) _____(night)
7. Toilet train (Bowel) _____(day) _____(night)
8. Approximately how long did toilet training take from onset to completion? _____

DEVELOPMENTAL HISTORY:

1. How is his/her hearing?

2. How is his/her vision? Is he/she colorblind?

3. How is his/her gross (large) motor coordination?

4. How is his/her fine (small) motor coordination?

5. How is his/her speech, articulation, language processing?

6. Has your child had any chronic health problems (e.g. asthma, allergies, diabetes, heart conditions, etc.)? If so, please specify onset, duration, and any residual problems as a result of the condition.

7. Has you child had any of the following: head injury, convulsions, coma, and/or persistent high fevers?

8. Do you know or suspect that your child is using any nonprescription medications and or alcohol?

9. Is there any history of sexual, physical, or emotional abuse? If so, please describe.

10. Does your child have any difficulty sleeping at night? If so, what kind of difficulties?

11. Does your child have any difficulties with eating, or more generally, with his/her appetite? What is their relationship with food?

12. Has your child suffered any signifigant losses or transitions?

13. How did your child handle the Covid-19 Pandemic?

EDUCATIONAL OR LEARNING CONCERNS

1. How is your child performing at school at the present time with regard to reading, math, and other academic skills?

2. Does your child receive special education services? Do they have an IEP or 504 plan? If so, what are their accommodations/goals? (Please provide a copy of their current IEP or 504 Plan.)

3. To the best of our knowledge, do you feel your child is performing at grade level?

4. Does your child complete assignments in a timely, organized fashion?

5. Does he/she understand/follow directions?

6. Is he/she attentive and focused in class?

7. Does your child receive any educational support or therapies outside of school?

8. Briefly describe your child's experience and note the name and grades completed at:

a. Preschool

b. Elementary school

c. Middle school

d. High school

9. Have your child's teachers expressed concerns about them?

PEER RELATIONSHIPS

1. How does your child get along with his/her siblings?

2. Does your child seek out friendships with peers?

3. Is your child sought out by peers?

4. Does your child prefer to play with children who are approximately the same age?

5. Describe any concerns about peer-related problems.

PSYCHIATRIC HISTORY:

1. Has your child evidenced difficulties in one or more of the following areas: Mood (i.e. sadness, elation), anxiety, impulsivity/hyperactivity, aggression, or judgment?

2. Have you ever consulted with a mental health professional about your child? If so, please specify why, when, and with whom.

3. Has your child ever been evaluated by a psychiatrist or psychologist? If so, briefly describe the findings.

4. Has medication ever been prescribed for psychiatric, behavioral, attention, or learning problems? If so, what medications and when. Please specify if any medications are being taken currently.

5. Are there any family history of psychiatric, neurological, and/or learning disabilities in your extended family? (Please focus on first degree relatives – siblings, grandparents, parents)

6. Please describe any other concerns or issues