1303 Fifth St., Suite 202
Coralville, IA 52241
phone 319.358.6520
fax 319.538.0093

CHILD/ADOLESCENT INTAKE FORM

CHILD'S LEGAL NAME: ____ NICKNAME: ______________________
LAST FIRST MIDDLE

CHILD'S ADDRESS: ____________________________ ________________________ ________________ ________
STREET CITY STATE ZIP CODE

CHILD'S D.O.B.: _______/________/_________ AGE: ________ GRADE: ________ SCHOOL: ______________________

CHILD'S PRIMARY M.D. ________________________________ CLINIC: _______________________________________

WHO REFERRED YOU TO OUR OFFICE? _________________________ REASON FOR REFERRAL: _______________________

CHILD IS LIVING WITH: ❒ NATURAL PARENTS ❒ ADOPTIVE PARENTS ❒ ONE PARENT ALONE

❒ PARENT & STEP PARENT ❒ OTHER: ____

STATUS OF PARENTS: ❒ MARRIED ❒ SEPARATED ❒ DIVORCED ❒ WIDOWED ❒ UNMARRIED

❒ OTHER (SPECIFY): ____

OK TO CONTACT THROUGH EMAIL? Y N (PLEASE CIRCLE) E-MAIL ADDRESS: ______________________________

PARENT 1: ______________________________________ ❒ BIOLOGICAL ❒ ADOPTIVE ❒ STEP

ADDRESS: ____ CITY: __________________ STATE: _________ ZIP: ________

HOME PHONE: (______) _______________ CELL PHONE: (_____) _______________ WORK PHONE: (_____) ______________

Is parent employed outside the home? Y N Does parent live with child/adolescent? Y N

PLACE OF EMPLOYMENT: ______________________ OCCUPATION: ______________________________

PARENT 2: ______________________________________ ❒ BIOLOGICAL ❒ ADOPTIVE ❒ STEP

ADDRESS: ____ CITY: __________________ STATE: _________ ZIP: ________

HOME PHONE: (______) _______________ CELL PHONE: (_____) _______________ WORK PHONE: (_____) ______________

Is parent employed outside the home? Y N Does parent live with child/adolescent? Y N

PLACE OF EMPLOYMENT: ______________________ OCCUPATION: ______________________________

IF OTHER CAREGIVERS, PLEASE LIST BELOW:

CAREGIVER'S NAME: ______________________________________ RELATION TO CHILD/ADOLESCENT: _______________

ADDRESS: ____ CITY: __________________ STATE: _________ ZIP: ________

HOME PHONE: (______) _______________ CELL PHONE: (_____) _______________ WORK PHONE: (_____) ______________

Is caregiver employed outside the home? Y N Does caregiver live with child/adolescent? Y N

PLACE OF EMPLOYMENT: ______________________ OCCUPATION: ______________________________

CAREGIVER'S NAME: ____ RELATION TO CHILD/ADOLESCENT: _____________________

ADDRESS: ____ CITY: _________________________ STATE: _____________ ZIP: __________

HOME PHONE: (_______) _____________________ CELL PHONE: (______) ______________________ WORK PHONE: (______) ____________________

Is caregiver employed outside the home? Y N Does caregiver live with child/adolescent? Y N

PLACE OF EMPLOYMENT: ________________________________ OCCUPATION: ____

What are the current concerns? Please list in order of importance:

1. ____

2. ____

3. ____

How has the family attempted to deal with these concerns? List the 3 most common methods:

1. ____

2. ____

3. ____

What are the strengths of this child/adolescent?

1. ____ 3. ____

2. ____ 4. ____

In what situations or circumstances is this child/adolescent most likely to experience difficulty?

1. ____ 3. ____

2. ____ 4. ____

What does this child/adolescent like to do?

Activities: ____

Hobbies: ____

Leisure Time: ____

Previous counseling/mental health/psychiatric services? List providers, dates and reasons:

____

____

____

CHILD'S BROTHERS AND SISTERS

NAME:	SEX:	AGE:	GRADE IN SCHOOL OR HIGHEST COMPLETED:	LIVING IN HOME?	HEALTH OR LEARNING PROBLEMS, IF ANY:
______________________	___	___	___________________	______	_____________________
______________________	___	___	___________________	______	_____________________
______________________	___	___	___________________	______	_____________________
______________________	___	___	___________________	______	_____________________

In what joint activities do you engage as a family?

Activity	Frequency (rarely, occasionally, often)
1. ______________________	__________________________
2. ______________________	__________________________
3. ______________________	__________________________

DEVELOPMENTAL HISTORY

PREGNANCY AND BIRTH HISTORY

AGE OF MOTHER AT DELIVERY: ___________________________

ANY KNOWN HEALTH PROBLEMS OF MOTHER DURING PREGNANCY: ____

ANY POST-PARTUM DEPRESSION OR ANXIETY: ____

ANY COMPLICATIONS DURING LABOR AND DELIVERY: ____

DELIVERY WAS: ❒ VAGINAL ❒ CAESAREAN

ANY HEALTH PROBLEMS RIGHT AFTER BIRTH? ❒ YES ❒ NO

IF YES, PLEASE EXPLAIN: ____

BIRTH WEIGHT: _______________________________________

BABY WAS: ❒ FULL-TERM ❒ PREMATURE IF PREMATURE, BY HOW MANY WEEKS? ____________________________________

WHAT SUBSTANCES, IF ANY, DID THE MOTHER USE DURING THE COURSE OF PREGNANCY (INDICATE FREQUENCY) ?

Alcohol	Caffeine	Nicotine	Street drugs
❒ Never	❒ Never	❒ Never	❒ Never
❒ Rarely	❒ Rarely	❒ One or two daily	❒ Once or twice
❒ Once each week	❒ Once each week	❒ Half pack daily	❒ Rarely
❒ Once each day	❒ Once each day	❒ One pack daily	❒ Often
❒ More than once daily	❒ More than once daily	❒ More than one pack/day	❒ Frequently

PLEASE LIST STREET DRUGS (IF APPLICABLE): ____

WHAT MEDICATIONS, IF ANY, DID THE MOTHER USE DURING THE COURSE OF PREGNANCY?

❒ Valium, Librium, Xanax or other anti-anxiety medications
❒ Antidepressants
❒ Anti-seizure medications
❒ Antipsychotics
❒ Tranquilizers/sleep aids
❒ Treatment for diabetes
❒ Antibiotics
❒ Other (specify): _________________

POSTNATAL PERIOD AND INFANCY

WERE THERE ANY FEEDING PROBLEMS DURING INFANCY?

❒ Yes ❒ No If yes, specify: ____

WAS THIS CHILD/ADOLESCENT COLICKY AS AN INFANT?

❒ Yes ❒ No

WERE THERE EARLY INFANCY SLEEP PATTERN DIFFICULTIES?

❒ Yes ❒ No If yes, specify: ____

WERE THERE PROBLEMS WITH THE INFANT'S RESPONSIVENESS/ALERTNESS?

❒ Yes ❒ No If yes, specify: ____

HOW "EASY" WAS THIS CHILD/ADOLESCENT AS AN INFANT?

❒ Very easy ❒ Easy ❒ Average ❒ Difficult ❒ Very difficult

DID THIS CHILD/ADOLESCENT EXPERIENCE ANY HEALTH PROBLEMS DURING INFANCY OR TODDLER YEARS?

❒ Yes ❒ No If yes, specify: ____

AS AN INFANT/TODDLER, HOW DID THIS CHILD/ADOLESCENT BEHAVE WITH OTHER PEOPLE?

❒ Avoided social contact ❒ More shy than average ❒ Average sociability ❒ More sociable than average

AS AN INFANT/TODDLER, HOW INSISTENT WAS THIS CHILD/ADOLESCENT WHEN THEY WANTED SOMETHING?

❒ Not insistent ❒ Average ❒ Somewhat insistent ❒ Very insistent

HOW WOULD YOU RATE THE ACTIVITY LEVEL OF THIS CHILD/ADOLESCENT AS AN INFANT/TODDLER?

❒ Not active ❒ Less active ❒ Average ❒ More active ❒ Very active

HOW WOULD YOU DESCRIBE THE INFANT/TODDLER'S TYPICAL PLAY?

❒ Played alone ❒ Imaginative/make-believe ❒ Quiet
❒ Interested in playing with others ❒ Rigid, concrete ❒ Loud
❒ Repetitive

WHAT WERE THE FAVORITE PLAY ACTIVITIES AS A TODDLER/PRESCHOOLER? ____

DEVELOPMENTAL MILESTONES

HAVE YOU OR ANYONE ELSE EVER HAD CONCERNS ABOUT THIS CHILD/ADOLESCENT'S DEVELOPMENT?

❒ Yes ❒ No If yes, specify: ____

WAS YOUR CHILD SLOW TO DEVELOP MOTOR SKILLS OR AWKWARD COMPARED TO PEERS? (e.g., running, skipping, climbing, biking, playing ball)

❒ Yes ❒ No If yes, specify: ____

AT WHAT AGE DID (S)HE: SIT UP: __________________________ CRAWL: __________________________ WALK: ____________________________

HANDEDNESS: ❒ LEFT ❒ RIGHT ❒ AMBIDEXTROUS

FAMILY HISTORY OF LEFT-HANDEDNESS (LIST RELATIVES): ____

AT WHAT AGE WAS (S)HE TOILET TRAINED? ________________________________

ANY PROBLEMS WITH BEDWETTING, ACCIDENTS OR SOILING? ____

WAS PHYSICAL THERAPY EVER NECESSARY? ____

WAS OCCUPATIONAL THERAPY EVER NECESSARY? ____

WAS SPEECH/LANGUAGE THERAPY EVER NECESSARY? ____

AT WHAT AGE DID (S)HE SPEAK FIRST WORD? ________________________________ PUT 2-3 WORDS TOGETHER? _________________________

ANY ORAL MOTOR PROBLEMS? (e.g., late drooling, poor sucking, poor chewing) ____

WAS CHILD SLOW TO: ❒ LEARN THE ALPHABET ______________ ❒ NAME COLORS _____________ ❒ COUNT _____________

ANY SPEECH DELAYS OR PROBLEMS? (e.g., stuttering, difficult to understand) ____

DOES YOUR CHILD HAVE UNUSUAL LANGUAGE? (DESCRIBE) ____

OTHER LANGUAGES SPOKEN AT HOME BESIDES ENGLISH: ____

SOCIAL BEHAVIOR

DOES YOUR CHILD:

GET ALONG WITH OTHER CHILDREN?	❒ Yes	❒ No
ENGAGE IN IMAGINATIVE PLAY ACTIVITIES?	❒ Yes	❒ No
GET ALONG WITH ADULTS?	❒ Yes	❒ No
HAVE FRIENDS?	❒ Yes	❒ No
KEEP FRIENDS?	❒ Yes	❒ No
UNDERSTAND GESTURES?	❒ Yes	❒ No
HAVE A GOOD SENSE OF HUMOR?	❒ Yes	❒ No
UNDERSTAND SOCIAL CUES SUCH AS WHEN OTHERS ARE ANGRY?	❒ Yes	❒ No
FEEL UNCOMFORTABLE, NEED SUPPORT?	❒ Yes	❒ No
HAVE PROBLEMS WITH PEER PRESSURE? (e.g., alcohol/drug use)	❒ Yes	❒ No

---

EDUCATIONAL HISTORY

PLEASE SUMMARIZE YOUR CHILD/ADOLESCENT'S ACADEMIC, BEHAVIORAL AND EMOTIONAL PROGRESS WITHIN EACH OF THESE GRADE LEVELS. INCLUDE ANY TEACHER COMMENTS OR OBSERVATIONS:

Name of School

PRESCHOOL/DAYCARE: ____ ____

____

ELEMENTARY: ____ ____

____

JUNIOR HIGH: ____ ____

____

HIGH SCHOOL: ____ ____

____

HAS THE CHILD/ADOLESCENT REPEATED ANY GRADES?

❒ Yes ❒ No If yes, what grade(s) and why? ____

HAS THE CHILD/ADOLESCENT EVER BEEN IN ANY TYPE OF SPECIAL EDUCATION PROGRAM, AND IF SO, DURING WHICH GRADE(S)?

Program	Grade(s)
❒ Learning disabilities (LD)	______________________
❒ Resource room	______________________
❒ Emotional/behavioral disorders (EBD)	______________________
❒ Speech/language therapy	______________________
❒ Occupational therapy	______________________
❒ Adaptive physical education	______________________
❒ Autism services	______________________
❒ Other: ___________________	______________________

HAS THE CHILD/ADOLESCENT EVER BEEN IN ANY TYPE OF SUPPLEMENTARY PROGRAM, AND IF SO, DURING WHICH GRADE(S)?

Program	Grade(s)
❒ Chapter 1 help in reading/math	______________________
❒ 504 plan	______________________
❒ Gifted programs	______________________
❒ Social skills group	______________________
❒ Other: ___________________	______________________

CHILD/ADOLESCENT'S TYPE OF PLACEMENT IN SCHOOL:

❒ Regular ❒ Learning Disability ❒ Behavior Disorder ❒ Resource Room ❒ Intellectual Delays ❒ Other

TEACHER'S NAME: ____ COUNSELOR'S NAME: ____

CHILD/ADOLESCENT'S STRENGTHS IN SCHOOL SUBJECTS: ____

CHILD/ADOLESCENT'S WEAKNESSES IN SCHOOL SUBJECTS: ____

IS THE SCHOOL DOING A GOOD JOB OF HANDLING YOUR CHILD/ADOLESCENT'S STRENGTHS OR WEAKNESSES? ____________________________

DISCIPLINE PHILOSOPHY

WHO ORDINARILY DISCIPLINES YOUR CHILD? ____

DO THE ADULTS CARING FOR THIS CHILD AGREE ON DISCIPLINE? ____

HOW IS YOUR CHILD DISCIPLINED:

❒ SPANK ❒ TAKE AWAY PRIVILEGES ❒ YELL ❒ SEND TO ROOM ❒ TALK TO OR REASON WITH ❒ TIME OUT

❒ ASSIGN EXTRA CHORES ❒ OTHER: ____

DO YOU REWARD YOUR CHILD FOR OBEYING OR BEHAVING WELL?	❒ Often	❒ Sometimes	❒ Never
DO YOU IGNORE YOUR CHILD WHEN HE/SHE IS MISBEHAVING?	❒ Often	❒ Sometimes	❒ Never
DO YOU ASK YOUR CHILD WHAT HIS/HER PLANS ARE FOR THE DAY?	❒ Often	❒ Sometimes	❒ Never
DOES YOUR CHILD TALK YOU OUT OF BEING PUNISHED?	❒ Often	❒ Sometimes	❒ Never
DO YOU LET YOUR CHILD OUT OF PUNISHMENTS? (e.g., lifting restrictions earlier than you originally said)	❒ Often	❒ Sometimes	❒ Never

---

MEDICAL HISTORY

HOW WOULD YOU DESCRIBE YOUR CHILD'S HEALTH?

❒ Very Good ❒ Good ❒ Fair ❒ Poor ❒ Very Poor

HOW IS HIS/HER:

				Specify any problems:
HEARING:	❒ Good	❒ Fair	❒ Poor	________________________
SPEECH/LANGUAGE:	❒ Good	❒ Fair	❒ Poor	________________________
GROSS MOTOR COORDINATION:	❒ Good	❒ Fair	❒ Poor	________________________
FINE MOTOR COORDINATION:	❒ Good	❒ Fair	❒ Poor	________________________
VISION:	❒ Good	❒ Fair	❒ Poor	________________________

DOES YOUR CHILD WEAR GLASSES? ________________________________

ARE IMMUNIZATIONS UP TO DATE? ________________________________ ANY MEDICINAL ALLERGIES? ________________________________

WHICH OF THE FOLLOWING ILLNESSES HAS THE CHILD HAD? (check all that apply)

❒ Stomach aches	❒ High fevers	❒ Asthma	❒ Food allergies
❒ Constipation	❒ Chronic diarrhea	❒ Urinary tract infection	❒ Chronic pain
❒ Lead poisoning	❒ RSV	❒ Chicken pox	❒ Chronic ear infections
❒ Croup	❒ Pneumonia	❒ Encephalitis	❒ Chronic headaches
❒ Seizures	❒ Other (specify): ____		

IS THERE A HISTORY OF (check all that apply):

❒ Headaches	❒ Depression	❒ High Anxiety	❒ Abdominal pains/vomiting
❒ Febrile seizures	❒ Epilepsy/seizures	❒ Loss of consciousness	❒ Sleep difficulties (including nightmares)
❒ Impulsivity	❒ Hyperactivity	❒ Clumsiness	❒ Self-injurious behavior
❒ Frequent ear infections	❒ Asthma or allergies	❒ Temper tantrums	❒ Nail biting
❒ Head banging	❒ Failure to thrive	❒ Thyroid disorder	❒ Breath holding
❒ Abuse toward animals	❒ Physical/sexual abuse	❒ Diabetes	❒ Drug or alcohol use
❒ Tics/twitching	❒ Kidney disease	❒ Blood disorder	❒ Lead poisoning/toxic ingestion
❒ GI disease	❒ Lung disease	❒ Heart disease	❒ Obsessive-compulsive behavior
❒ Repetitive movements (e.g., hand flapping)			

HAS YOUR CHILD/ADOLESCENT HAD ANY OTHER MEDICAL PROBLEMS ASIDE FROM USUAL CHILDHOOD ILLNESSES?

❒ Yes ❒ No If yes, specify: ____

LIST SERIOUS ILLNESSES/INJURIES/SURGERIES/HOSPITALIZATIONS (INCLUDE PSYCHIATRIC HOSPITALS):

Date or age of child	Incident (please explain)
______________	____
______________	____
______________	____

HAS YOUR CHILD/ADOLESCENT HAD ANY ACCIDENTS RESULTING IN THE FOLLOWING? (check all that apply)

❒ Broken bones ❒ Loss of consciousness ❒ Severe lacerations ❒ Head injury
❒ Severe bruises ❒ Eye injury ❒ Sutures ❒ Loss of teeth

If yes, please explain: ____

DOES YOUR CHILD/ADOLESCENT HAVE BLADDER CONTROL PROBLEMS? ❒ Yes ❒ No If yes, when specifically? _______________

DOES YOUR CHILD/ADOLESCENT HAVE BOWEL CONTROL PROBLEMS? ❒ Yes ❒ No If yes, when specifically? _______________

TYPICAL BEDTIME: ____________________________

DESCRIBE THIS CHILD/ADOLESCENT'S SLEEP PATTERNS/HABITS:

❒ Sleeps all night without disturbance ❒ Difficulty falling asleep ❒ TV in bedroom
❒ Awakens during the night/restless ❒ Early morning awakening ❒ Watches TV/plays video games up to bedtime
❒ Severe snoring ❒ Sleeps outside of bedroom ❒ Gets up after bedtime to watch TV/play games
❒ Sleepwalking

DESCRIBE THIS CHILD/ADOLESCENT'S APPETITE:

❒ Overeat ❒ Average ❒ Under eat ❒ Binge

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD/ADOLESCENT'S EATING HABITS?

❒ Yes ❒ No If yes, please explain: ____

DESCRIBE YOUR CHILD/ADOLESCENT'S CURRENT ACTIVITY/ENERGY LEVEL:

❒ Hyperactive ❒ Active/alert ❒ Average ❒ Under active/lethargic

HAS YOUR CHILD EVER RECEIVED MEDICATIONS IN THE PAST FOR EMOTIONAL, PHYSICAL, LEARNING OR BEHAVIORAL PROBLEMS?

❒ Yes ❒ No If yes, please give the following details:

PROBLEM: ____

AGE: ___________ MEDICATION: ____________________________________ DAILY DOSE: ____

TIMES PER DAY: ___________________________________ HOW LONG WAS IT TAKEN? ____

DID IT HELP? ____ SIDE EFFECTS: ____

IS YOUR CHILD/ADOLESCENT PRESENTLY TAKING ANY MEDICATION?

❒ Yes ❒ No If yes, please give the following details:

MEDICATION: ____

DAILY DOSE: _________________________________ TIMES PER DAY: ______________________________

TAKEN SINCE: ____ WHO PRESCRIBED MEDICATION? _______________________________

IS IT HELPING? ____ SIDE EFFECTS: ____

OTHER MEDICATIONS AND DOSES (INCLUDE OVER THE COUNTER MEDICINES):

____

____

FAMILY HISTORY OF MENTAL HEALTH AND CHEMICAL DEPENDENCY

CHECK ALL THAT APPLY TO CHILD/ADOLESCENT'S BIOLOGICAL FAMILY AND CARETAKERS:

	Biological Mother/ Her Family	Biological Father/ His Family	Siblings/Other Caretaker(s) ______________	______________
Problems with attention, hyperactivity or impulse control				
Problems with aggressive, defiant and oppositional behavior as a child				
Arrests / antisocial behavior				
Learning Disabilities				
Mental Retardation				
Autism				
Depression for longer than two weeks				
Suicidal thoughts or attempts				
Bipolar Disorder				
Anxiety Disorder (worry, nervousness, panic)				
Obsessive-Compulsive Behavior				
Eating Disorder				
Psychosis or Schizophrenia				
Alcohol abuse or dependence				
Drug abuse or dependence				
Victim of physical abuse				
Victim of sexual abuse				
Other (specify): _________________________				

SEXUAL ABUSE HISTORY

	Yes	No	Don't Know
Has your child/adolescent ever been exposed to inappropriate pornographic material?			
Has anyone ever exposed him/herself to your child/adolescent?			
Has anyone had sexual activity with your child/adolescent against their will?			
Has your adolescent been sexually involved with someone at least four years older than him/her?			
Have any of the above incidents been reported to social services?			

LIFE CHANGES OR STRESSFUL EVENTS

WHICH OF THE FOLLOWING MAJOR LIFE EVENTS HAVE TAKEN PLACE IN YOUR CHILD'S LIFE? PLEASE CHECK ALL THAT APPLY:

	Experienced event within last 12 months	Experienced event more than one year ago	Please describe
Change in residence	❐	❐	____________________________
Change in living conditions	❐	❐	____________________________
Change in schools	❐	❐	____________________________
Change in recreational habits	❐	❐	____________________________
Change in church activities	❐	❐	____________________________
Change in social activities	❐	❐	____________________________
Change in eating habits	❐	❐	____________________________
Change in sleeping habits	❐	❐	____________________________
Change in number of family gatherings	❐	❐	____________________________
Addition to family	❐	❐	____________________________
Change in family member's health	❐	❐	____________________________
Death/loss of family member	❐	❐	____________________________
Death/loss of friend	❐	❐	____________________________
Illness or injury to child	❐	❐	____________________________
Illness or injury to family	❐	❐	____________________________
Divorce of parents	❐	❐	____________________________
Marital separation of parents	❐	❐	____________________________
Job change or parent	❐	❐	____________________________
Change in family financial status	❐	❐	____________________________
Pregnancy of mother	❐	❐	____________________________
Jail term for parent	❐	❐	____________________________
Trouble with extended family	❐	❐	____________________________
Family violence	❐	❐	____________________________
Minor law violations	❐	❐	____________________________
Arrests/imprisonments	❐	❐	____________________________
Foster care/other placement outside of home	❐	❐	____________________________
Verbal/emotional abuse	❐	❐	____________________________
Physical abuse	❐	❐	____________________________
Sexual abuse	❐	❐	____________________________
Family chemical abuse	❐	❐	____________________________
Child chemical abuse	❐	❐	____________________________
Starting or finishing something new in school	❐	❐	____________________________
Outstanding personal achievement	❐	❐	____________________________

Today's Date: ______ / ______ / ______