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NEW PATIENT INTAKE FORM

Child's Name: ____ Today's Date: __________________

Date of Birth: ____/____/____ Child's Age: _____________ Gender: ☐ Male ☐ Female

Your Name: ____ Relationship: __________________

Child's Address: ____

____

Cultural/Ethnic Information (please indicate any considerations you would like me to take): ________________

____

FAMILY INFORMATION

Please list all significant parental figures involved in the child's life (i.e., parents, step-parents, guardians, etc.)

Name	Relationship	Age	Gender	Phone number	Address (if different from child)

Is this child adopted? _________ Age at adoption: _________ Are biological parents involved? _______

Marital status of the child's parents: ☐ Married ☐ Cohabitating ☐ Separated ☐ Divorced ☐ Other:______

If parents are divorced, who has legal custody of the child? ____

Please describe custody arrangements: ____

Please list all siblings:

Name	Age	Gender	Living in the home?	Relationship (full, half, step)

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Does your child have an existing developmental and/or mental health diagnosis from a physician or psychologist? If yes, please list the diagnosis, date of diagnosis, and who gave the diagnosis.

____

____

Has your child ever received therapy in the past? If yes, please describe what worked/did not work.

____

____

Identify the main problems of concern.

____

____

____

____

Identify what you have tried and/or done in the past to help your child.

____

____

____

Identify your child's strengths.

____

____

____

Identify 3-4 goals for our work together.

1. ____

2. ____

3. ____

4. ____

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DEVELOPMENTAL HISTORY

List any complications during pregnancy: ____

____

List any substances used during pregnancy: ____

Type of delivery: ☐ Vaginal ☐ C-Section Baby's weight at birth: ________________

List any complications during labor/delivery: ____

____

List any concerns immediately after birth: ____

____

Age spoke first words: _____ Age spoke in sentences: _____ Age first crawled: _____ Age first steps: _____

List any concerns regarding child's development: ____

____

HEALTH HISTORY

Describe any history of medical issues (i.e., illnesses, injuries, surgeries, accidents).

____

____

____

List any prescription medications that your child is currently taking.

Medication	Dosage	Reason Taken	Prescribing Physician

Identify any negative side effects and your impression of impact.

____

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EDUCATIONAL HISTORY

Current School: _________________________________ District: _____________________ Grade: _______

Teacher's Name: ________________ Type of Classroom: ☐ General Education ☐ Inclusion ☐ Self-Contained

Check if your child has: ☐ Individualized Education Plan ☐ Section 504 Plan

Indicate whether your child currently or in the past has received the following services:

	Current	Past
Speech Therapy		
Physical Therapy		
Occupational Therapy		
Math Intervention		
Reading Intervention		
Behavior Plan		
Other:		

Identify any concerns you or your child's teacher has regarding school.

____

____

____

FAMILY HISTORY

Indicate members of immediate/extended family who have been diagnosed with, or suspected to have.

Diagnosis/Problem	*Family member's relationship to your child*
ADHD	
Anxiety	
Autism Spectrum Disorder	
Bipolar Disorder	
Depression	
Learning Difficulties	
Oppositional Defiant Disorder/behavior issues	
Problems with alcohol/substance use	
Schizophrenia	

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Are you or a professional concerned about any of the following in your child?

Diagnosis or Problem	*Write yes, if applicable, then who is concerned (e.g., parents, teacher, physician, etc.)*
Aggression	
Anger when told “no”	
Anxiety	
ADHD	
Autism Spectrum Disorder	
Bipolar Disorder	
Behavior or Discipline Problems at Home	
Behavior or Discipline Problems at School	
Being easily distracted	
Depression	
Difficulties expressing emotions with words	
Difficulties making/keeping friends	
Fidgeting/moving about constantly	
Intellectual Disability	
Learning Difficulties	
Low self-esteem	
Muscle Twitches or Motor Tics	
Obsessive thoughts/compulsive actions	
Poor eye contact during social interactions	
Problems with drugs/alcohol	
Schizophrenia	
Suicidal behavior or thoughts	