JOETTE JAMES, PHD

LICENSED PSYCHOLOGIST
PEDIATRIC NEUROPSYCHOLOGIST

CHILD/ADOLESCENT INTAKE QUESTIONNAIRE

Information requested on this questionnaire is an important part of this child's evaluation. I appreciate your filling it out carefully and fully. Please feel free to add as much information as you want and to use the backs of pages if necessary.

The highest standards of professional confidentiality are maintained. Information about any particular individual can be released only with the explicit written consent of that person or their parent(s)/legal guardian except in exceptional legal circumstances. When consent to release information is granted, you may choose which information may/may not be released, and revoke that consent at any time.

Identifying information Today's Date _____

Person completing this form: _____ Relationship: _____

Child's full name: _____ Name called: _____ Age: _____

Birthdate: ____/____/____ Gender: ◯ M ◯ F Handedness: ◯ R ◯ L Height: _____ Weight: _____

Ethnicity: _____ Primary Language: _____ Other languages in the home: _____

Home address: _____

Home Phone: _____ Cell Phone(s): _____

Permission to leave phone messages: Home phone ◯ No ◯ Yes Cell phone: ◯ No ◯ Yes

Permission to email confidential information ◯ No ◯ Yes: email address _____

Who referred you for an evaluation? _____

Has this child ever been diagnosed with a learning disability? ◯ No ◯ Yes

Has this child ever been diagnosed with Attention Deficit Disorder? ◯ No ◯ Yes

Other diagnoses & medical conditions: _____

_____

Date of child's last psychological evaluation: _____ By whom? _____

Family Information

Parents/legal guardians:_____

With whom does the child live? _____

Frequency of contact with any biological parents not in the primary home? _____

If parents divorced, date of divorce _____

Date of mother's remarriage, if applicable: _____

Are there ☐ step-siblings? ☐ half-siblings? on the mother's side? ☐ Neither

Date of father's remarriage, if applicable: _____

Are there ☐ step-siblings? ☐ half-siblings? on the father's side? ☐ Neither

If child adopted (not living with either biological parent), age at time of adoption _____

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1. Biological Father's information

Name _____ Cell phone: _____

Address (if different):_____

Other Phone: _____ Email: _____

Occupation: _____ Highest Educational level: _____

Any difficulties in learning, attention, mood or behavior? ☐ No ☐ Yes: Describe: _____

_____

Any current or recent problems/stressors: _____

2. Biological Mother's information

Name _____ Cell phone: _____

Address (if different):_____

Other Phone: _____ Email: _____

Occupation: _____ Highest Educational level: _____

Any difficulties in learning, attention, mood or behavior? ☐ No ☐ Yes: Describe: _____

_____

Any current or recent problems/stressors: _____

3. Any significant (current) conflicts between biological parents? ☐ No ☐ Yes.

If parents are re-married, any significant marital conflicts on either side at the present time? ☐ No ☐ Yes

4. Other adults living in the child's home (part – or full-time): ☐ No ☐ Yes

Name _____ Cell phone: _____

Relationship _____ Occupation _____

Name _____ Cell phone: _____

Relationship _____ Occupation _____

5. Does this child have brothers or sisters? ☐ No ☐ Yes* (list all siblings, including step- / half- / adopted and indicate nature of relationship, and if the sibling lives in this child's primary home

Siblings' Names	Age	Grade	Step ?	Ha lf ?	Adopted ?	lives with him/her?	Describe any difficulties in learning, attention, behavior, mood, or other disabilities
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	

6. Other significant information about this child's biological family: Please indicate the existence of any of the following conditions in this child's biological family. Indicate the relationship of the person to this child (e.g., father, maternal grandmother, aunt, cousin, etc.) and describe the nature of the condition.

Reading Problems ☐ No ☐ Yes Who? _____ What? _____

Learning Problems ☐ No ☐ Yes Who? _____ What? _____

Attention Problems ☐ No ☐ Yes Who? _____ What? _____

Behavior Problems ☐ No ☐ Yes Who? _____ What? _____

Mental Health Disorders ☐ No ☐ Yes Who? _____ What? _____

Mental Retardation ☐ No ☐ Yes Who? _____ What? _____

Epilepsy ☐ No ☐ Yes Who? _____ What? _____

Serious Chronic Illness ☐ No ☐ Yes Who? _____ What? _____

Speech/Language Problems ☐ No ☐ Yes Who? _____ What? _____

Drug/Alcohol Abuse ☐ No ☐ Yes Who? _____ What? _____

Trouble with the Law ☐ No ☐ Yes Who? _____ What? _____

Additional comments: _____

_____

Birth History

1. Regarding the pregnancy with this child: Any problems, complications or concerns at all? ☐ No ☐ Yes

Bleeding? ☐ No ☐ Yes: Specify _____

Illness? ☐ No ☐ Yes: Specify _____

RH Incompatibility? ☐ No ☐ Yes: Specify _____

Exposure to cigarettes? ☐ No ☐ Yes: Specify _____

Exposure to alcohol or non-prescription drugs? ☐ No ☐ Yes: Specify _____

Length of pregnancy: ☐ Early: how early? _____ ☐ On time ☐ Late: how late? _____

Medications taken? ☐ No ☐ Yes: Specify _____

Describe any other unusual circumstances, such as bedrest,or any risk factors: _____

_____

2. Birth of this child: Any problems, complications or concerns at all? ☐ No ☐ Yes

Labor: False? ☐ No ☐ Yes Induced? ☐ No ☐ Yes Length: _____

Anesthesia? ☐ No ☐ Yes Natural? ☐ No ☐ Yes

Type of birth: Normal? ☐ No ☐ Yes Breech? ☐ No ☐ Yes Forceps? ☐ No ☐ Yes

Caesarean? ☐ No ☐ Yes Birthweight: _____ Apgar Score: _____

Complications: _____

Color: Normal? ☐ No ☐ Yes Blue? ☐ No ☐ Yes Jaundiced? ☐ No ☐ Yes

If jaundiced, how treated? _____

Transfusions? ☐ No ☐ Yes Incubator required? ☐ No ☐ Yes: How long: _____

Breathing Problems? ☐ No ☐ Yes Oxygen required? ☐ No ☐ Yes: How long: _____

Difficulties sucking, swallowing, or feeding? ☐ No ☐ Yes: Specify _____

Describe any other unusual circumstances _____

_____

Developmental History Any problems or concerns at all? ☐No ☐Yes

1. At what age did this child:

Sit alone: _____ Say his/her first word: _____

Walk alone: _____ Understand speech: _____

Use 2-word sentences: _____ Stop using baby talk: _____

Become toilet trained during the day: _____

Stop wetting the bed at night: _____

2. Did he/she have any problems in the following areas:

Learning the names of colors and shapes	☐No	☐Yes	Learning to tell time	☐No	☐Yes
Learning to riding a 2-wheeled bicycle	☐No	☐Yes	Learning to tie shoes	☐No	☐Yes
Learning to climb stairs, hop, or skip	☐No	☐Yes	Separating from parents	☐No	☐Yes
Learning to use zippers or buttons	☐No	☐Yes	Making friends	☐No	☐Yes
Reading aloud in class	☐No	☐Yes	Learning to read	☐No	☐Yes
Learning the names or sounds of letters	☐No	☐Yes	Learning to count or add	☐No	☐Yes
Learning how to write letters or numbers	☐No	☐Yes	Reciting the alphabet	☐No	☐Yes
Learning right and left	☐No	☐Yes	Learning to rhyme	☐No	☐Yes
Cutting with scissors	☐No	☐Yes	Learning a second language	☐No	☐Yes
Playing appropriately with toys	☐No	☐Yes	Making eye contact	☐No	☐Yes
Pointing to show interest	☐No	☐Yes	Sharing enjoyment	☐ No	☐ Yes

Describe anything else hard for him/her to learn as a preschooler: _____

_____

3. Did family, friends, etc. ever have difficulty understanding his/her speech? ☐No ☐Yes: Explain _____

_____

4. Has this child ever been evaluated by or worked with an Occupational Therapist (OT)? ☐No ☐Yes:

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

5. Has this child ever been evaluated by or worked with a Physical Therapist (PT)? ☐No ☐Yes:

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

6. Has this child ever been evaluated by or worked with Speech/Language Pathologist (SLP)? ☐No ☐Yes:

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

7. Has this child ever been evaluated by or worked with a vision therapist/behavioral optometrist? ☐ No ☐ Yes:

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

8. Has this child ever had an audiological evaluation? ☐ No ☐ Yes:

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

Medical History

1. Childhood illness

Ear infections? ☐ No ☐ Yes: Age(s): _____ Explain: _____

Frequent colds? ☐ No ☐ Yes: Age(s): _____ Explain: _____

Allergies? ☐ No ☐ Yes: Age(s): _____ Explain: _____

Meningitis? ☐ No ☐ Yes: Age(s): _____ Explain: _____

Encephalitis? ☐ No ☐ Yes: Age(s): _____ Explain: _____

Whooping cough? ☐ No ☐ Yes: Age(s): _____ Explain: _____

Scarlet fever? ☐ No ☐ Yes: Age(s): _____ Explain: _____

Pneumonia? ☐ No ☐ Yes: Age(s): _____ Explain: _____

2. Has this child received any blows to the head? ☐ No ☐ Yes: When? _____

Unconscious? ☐ No ☐ Yes: For how long? _____

How did it happen? _____

3. Has this child ever had seizures? ☐ No ☐ Yes: Age(s) _____

Did this child receive medication? ☐ No ☐ Yes: Specify: _____

When was the last seizure? _____ Known cause for the seizure(s)? _____

4. Has this child ever been evaluated or treated for any stress, anxiety, depression, or other types of psychological problems? ☐ No ☐ Yes: List therapists and ages/dates of treatment

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

Age/Dates: _____ Name: _____

5. Has this child ever had injuries or accidents requiring medical treatment? ☐ No ☐ Yes: Specify _____

_____

6. Has this child ever been hospitalized? ☐ No ☐ Yes: Age(s): _____

Why and for how long? _____

Current Medical Status

1. Describe this child's present health: _____ Last physical exam: _____

2. Last vision screening: _____ hearing screening: _____

3. Does this child wear glasses or contacts? ☐ No ☐ Yes: Age when prescribed ___ For what? _____

4. How is this child's appetite? _____

Any recent changes (increased or decreased)? ☐ No ☐ Yes: Describe _____

5. Average amount of sleep at night: _____ Is this adequate to function well? ☐ No ☐ Yes

Any recent changes (increased or decreased)? ☐ No ☐ Yes: Describe _____

Any problems getting this child to go to bed and/or falling asleep? ☐ No ☐ Yes: Specify _____

_____

6. Average number of hours: watching TV daily = _____ playing computer/video games daily = _____

7. Is your child sexually active? ☐ No ☐ Yes

8. Does your child drink alcohol, or use illegal drugs? ☐ No ☐ Yes Smoke cigarettes? ☐ No ☐ Yes

9. List current medications, including daily over-the-counter medications and dosage: _____

_____

_____

10. If applicable, list any other medications previously prescribed for a chronic illness or psychiatric or behavioral condition, and attach a separate page if necessary:

Type / Name	Dosage/ Frequency	When? (approx dates)	Reason

Educational History

1. List schools attended, including any/all day care centers and preschools:

School/Agency Name	City/State	Dates	Age/Grade

2. Child's best subject(s)? _____

3. Child's weakest subject(s)? _____

4. Does this child have any trouble doing his/her homework? ☐ No ☐ Yes: Describe _____

_____

_____

5. How are problems with homework usually handled? _____

_____

_____

6. How often does this child write down assignments in an agenda or planner? _____

7. How much homework is usually turned in? _____

8. Did this child skip any grades in school? ☐ No ☐ Yes: Which? _____

9. Did this child repeat any grades in school? ☐ No ☐ Yes: Which? _____

Why? _____

10. What things were hard for this child to learn in elementary school (such as reading, math, writing cursive, succeeding in physical education, making and keeping friends, conduct, completing seatwork)?

_____

_____

_____

11. How would this child's elementary school teachers describe him/her? _____

_____

12. Describe any behavior problems during the elementary school years: _____

_____

13. What things were hard for this child in middle and high school (such as writing compositions, reading long assignments, social skills, oral presentations, foreign language, algebra, geometry, study skills)?

_____

_____

_____

14. How would this child's middle and high school teachers describe him/her? _____

_____

15. Describe any behavior or conduct problems during the middle and high school years:

_____

_____

_____

16. High school GPA _____ Average English grades _____ Average Math grades _____

17. Middle/High School foreign language instruction:

Language: _____ Grade(s): _____ Average course grades _____

Language: _____ Number of years: _____ Average grades _____

18. List any honors, awards, or other kinds of special recognition this child has received: _____

_____

19. Best PSAT score (if taken): Verbal _____ Math _____ Writing _____

Accommodations: ☐ No ☐ Yes: Describe _____

20. Best SAT score (if taken): Verbal _____ Math _____ Writing _____

Accommodations: ☐ No ☐ Yes: Describe _____

Prep course? ☐ No ☐ Yes: Specify _____

21. Best ACT score (if taken): _____

Accommodations: ☐ No ☐ Yes: Describe _____

Prep course? ☐ No ☐ Yes: Specify _____

22: Any other college or graduate school standardized tests (e.g., AP, GRE, GMAT, MCAT, LSAT, Praxis)?.

☐ No ☐ Yes: Specify _____

23. Has this child ever worked with a private tutor? ☐ No ☐ Yes:

Grade(s) _____ Name _____ Reason _____

Grade(s) _____ Name _____ Reason _____

Grade(s) _____ Name _____ Reason _____

Grade(s) _____ Name _____ Reason _____

Grade(s) _____ Name _____ Reason _____

24. Has this child ever received any extra support in school? This would include work with a reading specialist, instructional specialist, para-educator, or school based tutor, placement in any special instructional groups or classes, or any kind of intervention plan, such as a 504 Plan, Accommodations Plan or IEP ☐ No ☐ Yes:

Grade(s) _____ What? _____

Grade(s) _____ What? _____

Grade(s) _____ What? _____

Grade(s) _____ What? _____

Grade(s) _____ What? _____

Grade(s) _____ What? _____

Social/Emotional and Behavioral Functioning

1. How would other children describe this child: _____

_____

2. Describe this child's friendships: A leader or follower? Easy to get along with? Older or younger friends?

_____

_____

3. Any problems in friendships (teasing, aggressiveness, rejection, etc.)? _____

_____

4. Does this child have best friends, or a consistent group of friends whose company he/she regularly enjoys outside of school? _____

5. Is this child regularly invited by others to play, or to attend parties? ☐ No ☐ Yes: How often? _____

6. What kinds of things does this child enjoy? _____

_____

_____

6. List current extracurricular activities: _____

_____

7. What household chores is he/she responsible for? _____

_____

8. How does this child earn money? _____

_____

9. What makes this child feel guilty? _____

10. How does this child show affection?_____

11. Is it hard for this child to trust others? ☐ No ☐ Yes Does he/she feel comfortable around others? ☐ No ☐ Yes

_____

12. How many times a week does this child feel really angry? _____What makes him/her feel that way? _____

_____ What does he/she do? _____

_____

13. Are there significant conflicts between this child and either or both parents? ☐ No ☐ Yes

14. Is this child a worrier? □ No □ Yes: What types of types of things does he/she worry about? _____

_____

15. Describe any nervous habits (nail biting, thumb sucking, hair pulling, etc.) _____

_____

16. Would you describe this child as obedient, or compliant with requests? _____

17. How is he/she punished? _____

For what and how often? _____

Is it effective?_____

18. Describe any unusual or problem behaviors not described above: _____

_____

19. Any recent changes or stressors in this child's life, or in the family? _____ Describe: _____

_____

20. On a scale of 1 to 10, rate the level of general stress in your home (with 10 = extremely stressful): _____

21. On average, how much time does this child spend with the <u>father</u> per week? _____

Typical activities together: _____

22. On average, how much time does this child spend with the <u>mother</u> per week? _____

Typical activities together: _____

23. Any other adults that this child regularly spends time with? _____

24. List any school suspensions or expulsions (dates and cause – attach school documentation if available)

_____

_____

Current Issues and Plans

1. What is <u>your</u> purpose in seeking this evaluation? _____

_____

_____

2. What do *you* believe is the cause(s) of this child's difficulties _____

_____

_____

3. What have others – spouse, other parents, teachers, therapists, etc. – said might be the cause(s) of this child's difficulties _____

_____

4. What do you think this child needs in order to be more successful, and to address the referral concerns:

_____

_____

_____

5. This child's reaction/thoughts about this evaluation: _____

_____

6. This child's physician's comments about his/her difficulties, and this evaluation: _____

_____

7. How have you and/or this child coped with his/her learning problems? _____

_____

_____

8. How does this child best learn things? _____

_____

_____

9. Describe this child's strengths: _____

_____

_____

10. Additional comments: _____

_____

_____

_____

_____

_____

_____

I have provided complete, true, and accurate information to the best of my knowledge. I understand that false or inaccurate information may invalidate my evaluation. I also understand that information on this form, and any information provided as part of this evaluation, can be released only to individuals designated by me and with my written consent, and that my consent can also be revoked by me, in writing, at any time.

_____ _____

Signature Date