Neuropsychological Consulting Services

834 Kenwood Ave., Suite 3
Slingerlands, NY 12159
Phone: 518-439-1641 Fax: 518-439-1625

www.NeuropsychologicalConsultingServices.com

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	_____	_____
seizures	_____	_____
tic disorder/Tourette syndrome	_____	_____
anxiety (general)	_____	_____
phobias	_____	_____
panic attacks	_____	_____
obsessive compulsive behaviors	_____	_____
depression	_____	_____
bipolar/manic depressive	_____	_____
anger control problem	_____	_____
substance abuse	_____	_____
eating disorders	_____	_____
schizophrenia	_____	_____

Is there any other information you would like to add?