Intake Information for Children's Hospital Department of Psychology

Thank you for completing the following questions. This information is confidential and will not be released without your permission.

BASIC INFORMATION ABOUT CHILD

Name _____ Today's Date _____

Gender Male Female Age _____ Child's Birthdate _____

Race/Ethnicity White (Caucasian) Black (African American)
Hispanic / Latino Asian / Pacific Islander
American Indian / Aleut / Eskimo Other _____

Current School _____ Parish _____ Grade _____

BASIC INFORMATION ABOUT CAREGIVER(S)

Legal Guardian Name _____ Relation to Child _____

Home Address _____ Home Phone _____

_____ Work Phone _____

Parish _____

Person completing this form _____

Who referred you here? _____ Title _____

Address _____ Phone _____

PRESENTING PROBLEMS

Briefly describe your child's current difficulties _____

_____

_____

_____

How long has this problem been a concern for you? _____

When did you first notice the problem? _____

Do any family members have similar problems? Yes No If yes, whom? _____

DEVELOPMENTAL HISTORY

PREGNANCY

Duration of pregnancy (weeks or months) _____

During the pregnancy did the mother

_____ Suffer from illness or disease
_____ Undergo surgery
_____ Take medication
_____ Have X-rays
_____ Use tobacco/smoke cigarettes
_____ Use alcohol
_____ Use drugs
_____ Suffer from an accident

Complications of this pregnancy included

_____ Excessive vomiting
_____ Excessive staining or blood loss
_____ Threatened miscarriage/premature labor
_____ Infection(s)
_____ Toxemia
_____ Diabetes
_____ High blood pressure
_____ Poor nutrition
_____ Amniocentesis
_____ Loss of consciousness in mother

DELIVERY

Duration of Labor _____ hours Birth Weight _____ Length _____

Type of Labor Spontaneous Induced Type of Delivery Normal Cesarean Breech

Complications

_____ None
_____ Cord around neck
_____ Problems with placenta
_____ Hemorrhage
_____ Delay in breathing
_____ Injury to infant
_____ Other (describe _____)

NEWBORN and POST-DELIVERY PERIOD

Was your baby in the Neonatal Intensive Care Unit (NICU)? Yes No If yes, how long? _____

Total days baby was in the hospital after delivery _____

Complications

_____ None
_____ Addiction
_____ Anemia
_____ Diarrhea
_____ Jaundice (yellow skin)
_____ Infection
_____ Seizures
_____ Vomiting
_____ Intraventricular hemorrhage
_____ Meconium staining or aspiration
_____ Needed respirator/resuscitation
_____ Cyanosis (turned blue)

INFANCY and TODDLER PERIOD

As a baby, the child was

_____ Active
_____ Cranky
_____ Calm
_____ Difficult
_____ Easy
_____ Happy
_____ Shy
_____ Sleepy
_____ Social
_____ Hard to please
_____ Lazy or slow moving
_____ Persistent

Were any of the following present in the first five years of life?

_____ Colic
_____ Difficulty sleeping
_____ Feeding problems
_____ Frequent headbanging
_____ Excessive restlessness
_____ Did not enjoy cuddling
_____ Constantly into everything
_____ Temper tantrums
_____ Clingy or difficulty separating from caregivers
_____ Slow or unable to adapt to changes in routines
_____ Excessively **high** or **low** activity level (circle one)
_____ Not calmed by being held and/or stroked
_____ Excessive number of accidents compared to other children
_____ Withdrawal or other problems adjusting to new people or situations
_____ Variable or irregular body functions (sleep, hunger, bowel movements, etc.)
_____ Reaction to or allergy to the DPT shot or pertussis vaccine

Were there any special problems in the development of the child during the first years? Yes No

If yes, please describe _____

_____

_____

DEVELOPMENTAL MILESTONES

Please indicate the age at which your child first demonstrated each of the following behaviors. If you are unsure, please write a question mark.

Behavior	Age
Sat up unassisted	_____
Walked alone	_____
Spoke first word	_____
Put several words together	_____
Became toilet trained (bladder)	_____
Became toilet trained (bowel)	_____
Stayed dry at night	_____
Fed self with fork or spoon	_____
Rode tricycle	_____

Compared to other children, how do you view your child's development? Normal Delayed Advanced

MEDICAL HISTORY

Please place a check next to any illness or condition that your child has. Please also note the date or child's age at the time of the illness.

Illness or Condition	Age/Dates	Illness or Condition	Age/Dates
_____ AIDS or HIV positive	_____	_____ Headaches	_____
_____ Allergies	_____	_____ Heart problems/disease	_____
_____ Anemia	_____	_____ Heavy metal poisoning	_____
_____ Aneurysm	_____	_____ Hepatitis	_____
_____ Anoxia	_____	_____ Herpes	_____
_____ Arteriovenous malformation	_____	_____ High blood pressure	_____
_____ Arthritis	_____	_____ Jaundice	_____
_____ Asthma	_____	_____ Leukemia	_____
_____ Ataxia	_____	_____ Malnutrition	_____
_____ Automobile accident	_____	_____ Meningitis	_____
_____ Back pain/problems	_____	_____ Muscular disease	_____
_____ Bleeding problems	_____	_____ Pain problems	_____
_____ Blood disorders	_____	_____ Paralysis	_____
_____ Bone or joint disease	_____	_____ Pituitary disorder	_____
_____ Broken bones	_____	_____ Pneumonia	_____
_____ Cancer	_____	_____ Poisoning	_____
_____ Coma	_____	_____ Rheumatic fever	_____
_____ Cystic Fibrosis	_____	_____ Scarlet fever	_____
_____ Dazed or unconscious	_____	_____ Sensory losses	_____
_____ Dementia	_____	_____ Sexual molestation	_____
_____ Diabetes	_____	_____ Speech/language problems	_____
_____ Dysarthria	_____	_____ Spells (_____)	_____
_____ Dyspraxia or Apraxia	_____	_____ Stroke	_____
_____ Ear infections (PE tubes)	_____	_____ Suicide attempt/thoughts	_____
_____ Other ear problems	_____	_____ Sunstroke/heat exhaustion	_____
_____ Eczema or hives	_____	_____ Thyroid disorder/problem	_____
_____ Encephalitis	_____	_____ Trauma (_____)	_____
_____ Epilepsy, seizures, fits	_____	_____ Tuberculosis	_____
_____ Fainting spells	_____	_____ Tumor	_____
_____ Fetal Alcohol Syndrome	_____	_____ Visual problems	_____
_____ Fever (if high or prolonged)	_____	_____ Whooping cough	_____
_____ Guillian-Barre Syndrome	_____	_____ Other medical problems:	
_____ Head injury	_____	_____	

Indicate if child has had any of these medical tests and if yes, indicate age/dates

_____ Electroencephalogram (EEG)	_____	_____ MRI scan	_____
_____ Skull X-rays	_____	_____ Opthalmological (vision)	_____
_____ CT scan	_____	_____ Audiological (hearing)	_____

Has your child ever suffered from a head injury which caused confusion/loss of consciousness? Yes No

Please list any chronic/serious illnesses or operations your child has had and child's age

_____