Licensed Psychologist (4619)

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A D O L E S C E N T / C H I L D I N T A K E

Name of Person Completing Form (if different than Child's Name): ____

Name of Child: ________________________________ Relationship to Child: ________________________________

Address: ____

Home Phone: __________________________________ Email: ____________________________________

Childs Date of Birth: ___________________________ Current Age: _______________________________________

School: ____

Grade: ______________________________________ Teacher's Name: ______________________________________

REFERRAL INFORMATION

I am seeking (circle all that apply):

Individual therapy Group Therapy Testing Consultation/Advice

Reason for seeking help:____

How were you referred to Dr. Escoto? ____

PARENAL INFORMATION

Mother's Name: ____________________________ Father's Name:__________________________________

Email: ____________________________________ Email:____

Phone: ____________________________________ Phone:_______________________________________

If parents are divorced who has custody of the child:____

PEER RELATIONSHIPS & BEHAVIOR

(circle all that apply)

- Prefers to be alone
- Has difficulty relating to same age peers
- Has difficulty making friends
- Has difficulty keeping friends
- Prefers playing with younger children
- Prefers playing with older children
- Frequently fights
- Easily overstimulated
- Short attention span
- Lacks self-control/regulation
- Seems unhappy
- Seems anxious/nervous
- Is overly energetic
- Is impulsive
- Is fearful
- Is a perfectionist

What makes the child angry:

____
____
____
____
____

What does the child enjoy doing:

____
____
____
____
____
____

SIBLING INFORMATION

Name/Age: ____

Name/Age: ____

Name/Age: ____

Name/Age: ____

FAMILY RELATIONSHIPS

Child's relationship with siblings?___________________

Child's relationship with parents? ___________________

What do you enjoy the most about your child?

____

____

What is the most challenging thing about your child?

____

____

What types of disciplinary strategies do you use at home?

____

____

FAMILY PSYCHOLOGICAL HISTORY

Drug/Alcohol abuse? Yes No____________________________

Mental/Emotional Issues? Yes No____________________________

Behavior Problems? Yes No____________________________

Anxiety/Nervousness? Yes No____________________________

Learning Problems? Yes No____________________________

Tics? Seizures? Yes No____________________________

Speech/language problems? Yes No____________________________

Received early intervention? Yes No ___________________________

Received special educational services? Yes No_________________

Child's Last Name: ____________________

EDUCATIONAL HISTORY

Current Grade:____

Current School: ____

Type of Classroom: ____

Currently has an Individual Education Plan (IEP)? Yes No

If yes, when was the IEP initiated? ____

When was the plan last updated? ____

Currently has a 504 Plan? Yes No

If yes, when was the 504 initiated? ____

When was the plan last imitated? ____

Preschool Name:____

Were or are there any concerns? Yes No

If yes, list them here: ____

Elementary School's Name: ____

Were or are there any concerns? Yes No

If yes, list them here: ____

High School's Name: ____

Were or are there any concerns? Yes No

If yes, list them here: ____

Ever been retained? Yes No

Expected to Progress to next grade? Yes No

PREGNANCY & BIRTH

Length of Pregnancy: _______________________ Birth Weight: ____________________________

Pregnancy complications: ____

Child's condition at birth: ____________________ Mother's condition at birth: ________________

Type of Birth: *Vaginal* *Caesarean* *Labor Induced* *Breech*

Length of hospital stay for child: _____________ For mother: _______________________________

Child's Last Name: ____________________

DEVELOPMENT

(Please note at what age your child met the following milestones)

Sat alone:____________ Stood alone: ______________ Walked alone: _____________

Spoke first word: _______________ Spoke in sentences:_____________________

Toilet trained: __________________

Did your child ever receive early intervention services (birth to three years)? Yes No

If yes, exactly what services were received & how for how long?

____

MEDICAL HISTORY

Pediatrician:_________________________________ Phone: __________________________________

Current Medication:____

Last Hearing Evaluation: _____________________ Last Vision Evaluation: ____________________

Psychiatrist:_________________________________ Last Visit: ________________________________

Neurologist: ________________________________ Last Visit:_________________________________

Speech/Language Pathologist: ____

Occupational Therapist: ____

Physical Therapist: ____

Prior Psychologist/Therapist:____

Has your child ever been hospitalized? Yes No

If yes, when and why?____

Any current health concerns?____

ITEMS TO BRING TO INTAKE

- Current Individual Education Plan (IEP), 504 Plan, and/or Functional Behavior Analysis Plan
- Prior reports from any other pediatric professional (e.g., Speech/Language Pathologists, Occupational Therapists, Physical Therapist, Neurologist, Developmental Pediatrician, etc.)
- Early Intervention Evaluation and/or Project Enlightenment Paperwork
- Current report card