



**Advanced Counseling and Testing Solutions, LLC**

**2121 Oregon Pike, Suite 201  
Lancaster, PA 17601  
T: 717-208-6599 F: 717-208-7753  
www.ACTSofLancaster.com**

**4 Wellington Blvd., Suite 101  
Wyomissing, PA 19610  
T: 484-987-7116  
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**Child / Adolescent / Testing Intake Background Data**

This questionnaire is to gather important background information on you that will assist us in providing you high quality care. Please answer the following questions to the best of your ability.

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender Identity:  Male  Female  Transgender ( MTF or  FTM)  Gender Neutral  
 Non-Binary  Additional category (please specify): \_\_\_\_\_

Parent or Parents (or Persons completing this form)

Name : \_\_\_\_\_

Family's Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Telephone Number (s):

Mobile: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Insurance: \_\_\_\_\_ Subscriber: \_\_\_\_\_

ID Number: \_\_\_\_\_ Carriers DOB: \_\_\_\_\_

Briefly state your main concerns regarding this child at home, school and community settings:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please note any specific questions you would like answered by this evaluation/Assessment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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Please indicate the outcomes or services you would like to result from this evaluation and or treatment:

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**FAMILY INFORMATION**

Biological Father \_\_\_\_\_ Age \_\_\_\_\_ Highest grade completed \_\_\_\_\_

Does child live with this parent? Yes \_\_\_\_\_ No (Explain) \_\_\_\_\_

Adoptive Father: Yes \_\_\_\_\_ No \_\_\_\_\_

Biological Mother \_\_\_\_\_ Age \_\_\_\_\_ Highest grade completed \_\_\_\_\_

Does child live with this parent? Yes \_\_\_\_\_ No (Explain) \_\_\_\_\_

Adoptive Mother Yes \_\_\_\_\_ No \_\_\_\_\_

If parents are separated or divorced, please indicate the date of divorce and describe present custody and visitation arrangements:

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***\*\*Please attach a copy of the custody order if one is present***

Primary language spoken at home: \_\_\_\_\_

Ethnic/Cultural Identification: \_\_\_\_\_

Does this child speak a second language? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, how well does he speak it? Fluently \_\_\_\_\_ Limited \_\_\_\_\_

List the names and information requested for all individuals living in the household (include siblings, stepparents, grandparents, etc.)

<i>Name</i>	<i>Relationship</i>	<i>Age</i>	<i>Comments</i>

Are there any siblings living outside the home? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain and list names and ages: \_\_\_\_\_

***Helping clients is our mission not only our profession!***



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Has any members of your family had *learning or school related problems*? Yes\_\_\_\_ No\_\_\_\_

If yes, please explain: \_\_\_\_\_

Have any members of your family had *behavior problems*? Yes\_\_\_\_ No\_\_\_\_

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

List any agencies and/or caseworkers involved with this child or your family:

\_\_\_\_\_

\_\_\_\_\_

Please describe any social stressors or family situations that may be affecting this child (e.g. death of family member, divorce, etc.):

\_\_\_\_\_

\_\_\_\_\_

**DEVELOPMENTAL HISTORY**

Was the pregnancy full-term (37 to 40 weeks)? Yes\_\_\_\_ No\_\_\_\_

Was the pregnancy with this child normal? Yes\_\_\_\_ No\_\_\_\_

If no, please explain: \_\_\_\_\_

Was the labor and delivery normal? Yes\_\_\_\_ No\_\_\_\_

If no, please explain: \_\_\_\_\_

\_\_\_\_\_



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Check any of the following that occurred:

- |   |  |
|---|--|
| <input type="checkbox"/> Induced delivery | <input type="checkbox"/> Medication to ease labor pains: Type: _____ |
| <input type="checkbox"/> Forceps          | <input type="checkbox"/> Cesarean section                            |
| <input type="checkbox"/> Suction          | <input type="checkbox"/> Breech delivery                             |
| <input type="checkbox"/> Other            | <input type="checkbox"/> Other                                       |

Check any of the following that occurred to the infant during or immediately following birth:

- |                             |   |
|-----------------------------|---|
| Injury during delivery      | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ |
| Cord around neck            | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ |
| Cardiopulmonary distress    | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ |
| Needed oxygen (turned blue) | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ |
| Had an infection            | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ |
| Birth defects               | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ |
| Incubation                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ |
| Was given medications       | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ |
| Seizures                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ |
| Jaundice                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ |

Explain any additional care this child needed: \_\_\_\_\_

\_\_\_\_\_

What was this child's birth weight? \_\_\_\_\_

Rate this child's overall development: Slow \_\_\_\_\_ Normal \_\_\_\_\_ Fast \_\_\_\_\_

Please explain and note any concerns you had with this child as an infant:

\_\_\_\_\_



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Indicate the age in which this child achieved the following milestones: (estimate if unsure)

- |                           |   |
|---------------------------|---|
| _____ Sat alone           | _____ First Words                             |
| _____ Crawled             | _____ Spoke short sentence (2 words together) |
| _____ Walked alone        | _____ Began to read                           |
| _____ Ran well            | _____ Toilet trained (day)                    |
| _____ Fed self with spoon | _____ Toilet trained (night)                  |
| _____ Tied shoes          | _____ Scribbled with pencil                   |

Do you have any concerns concerning this child’s motor or physical development? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

Do you have any concerns with this child’s speech or language development (e.g. stuttering, articulation difficulties, poor understanding, etc)? Yes \_\_\_\_\_ No \_\_\_\_\_

yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**MEDICAL INFORMATION**

How is this child’s overall health? Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Please list any emergency room services, surgeries or hospitalizations this child has received for physical or mental health conditions:

<i>Reason</i>	<i>Date</i>	<i>Age</i>	<i>Comments</i>

Does this child have any vision problems? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_



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Does this child have any hearing difficulties? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Please indicate whether or not this child has or has had any of the following conditions:

	Yes___ No__	Comments
Allergies	Yes___ No__	_____
Asthma	Yes___ No__	_____
Chronic illness (e.g. diabetes, etc.)	Yes___ No__	_____
Seizures/Convulsions	Yes___ No__	_____
Head Injuries	Yes___ No__	_____
Loss of consciousness	Yes___ No__	_____
High fevers (105 degrees or above)	Yes___ No__	_____
Motor or vocal tics	Yes___ No__	_____
Lead poisoning	Yes___ No__	_____
Dizziness/blurred vision	Yes___ No__	_____
Stomach pain	Yes___ No__	_____
Bladder difficulties	Yes___ No__	_____
Bowel problems	Yes___ No__	_____
Ear infections (how frequent)	Yes___ No__	_____
Broken bones	Yes___ No__	_____
Sleep problems (please describe)	Yes___ No__	_____
Frequent headaches	Yes___ No__	_____

List any medications this child takes on a regular basis:

<i>Medication</i>	<i>Dosage</i>	<i>Reason</i>



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Explain any side effects this child experiences from the above listed medications:

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Who monitors this child’s medication (list physician’s name and frequency of medication checks):

*(please include any physician’s name and address that your child currently sees on the permission to release form)*

Check any of the following therapies/treatments this child currently receives. If these services were received in the past, write the date next to the treatment.

- |  |   |
|--|---|
| <input type="checkbox"/> Speech and language therapy | <input type="checkbox"/> Music therapy        |
| <input type="checkbox"/> Occupational therapy        | <input type="checkbox"/> Vision therapy       |
| <input type="checkbox"/> Physical therapy            | <input type="checkbox"/> Hearing therapy      |
| <input type="checkbox"/> Other:                      | <input type="checkbox"/> Recreational therapy |

Has this child ever received a psychological or psychiatric evaluation? Yes\_\_\_\_ No\_\_\_\_

If yes, when, by whom, and what was the outcome (diagnosis, treatment, etc.)?

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*Please attach a copy of the most recent evaluation report to this form*

Check any of the following mental health or behavioral health services this child is currently receiving. If the child received these in the past, please list the date next to the service.

- |   |   |
|---|---|
| <input type="checkbox"/> Inpatient hospitalization  | <input type="checkbox"/> Partial hospitalization        |
| <input type="checkbox"/> Outpatient services        | <input type="checkbox"/> Wraparound services            |
| <input type="checkbox"/> Family-based mental health | <input type="checkbox"/> Residential treatment facility |
| <input type="checkbox"/> Drug and alcohol services  | <input type="checkbox"/> MH/MR case management          |
| <input type="checkbox"/> Medication management      | <input type="checkbox"/> Other:                         |



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**EDUCATIONAL INFORMATION**

Please list this child's school experiences, including preschool/Head Start:

<i>Grade(s)</i>	<i>School/City</i>	<i>Comments</i>

Has this child ever repeated or skipped a grade Yes\_\_\_ No\_\_\_

If yes, indicate which grade and reasons: \_\_\_\_\_

\_\_\_\_\_

Describe this child's academic and/or behavioral strengths at school:

\_\_\_\_\_

Describe this child's academic and/or behavioral weaknesses at school:

\_\_\_\_\_

Does the school share similar concerns regarding this child? Yes\_\_\_ No\_\_\_

If no, please explain: \_\_\_\_\_

Does this child presently receive any special services at school? Yes\_\_\_ No\_\_\_

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Has the school listened to your concerns regarding this child? Yes\_\_\_ No\_\_\_

If no, explain what you would have liked to be different: \_\_\_\_\_

Do you believe this child has made normal educational progress? Yes\_\_\_ No\_\_\_





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Do you think this child is in need of special education services? \_\_\_\_\_ Yes \_\_\_\_\_ No

Has this child had any prolonged absence from school? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, explain: \_\_\_\_\_

Does this child like to go to school? Yes\_\_\_ No\_\_\_

If no, explain: \_\_\_\_\_

Does this child have complaints about school? Yes\_\_\_ No\_\_\_

If yes, explain: \_\_\_\_\_

Please provide any additional information regarding this child's educational or school background.

\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL INTERACTIONS**

Does this child make friends easily? Yes\_\_\_ No\_\_\_

If no, explain: \_\_\_\_\_

Does this child prefer to play alone? Yes\_\_\_ No\_\_\_

If yes, explain: \_\_\_\_\_

Are this child's friends: Older\_\_\_ Same age\_\_\_ Younger\_\_\_

Do other children seek this child's friendship? Yes\_\_\_ No\_\_\_

Describe this child's social interaction skills: \_\_\_\_\_

\_\_\_\_\_



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**ADDITIONAL INFORMATION**

Provide information on this child's interests: \_\_\_\_\_

\_\_\_\_\_

List any activities this child dislikes: \_\_\_\_\_

\_\_\_\_\_

What types of discipline are used with his child at home (*indicate effectiveness*):

\_\_\_\_\_

\_\_\_\_\_

Has this child been involved in any legal issues (e.g. probation)? Yes\_\_\_ No\_\_\_

If yes, please explain: \_\_\_\_\_

Is this child able to complete age appropriate self-help skills (e.g. toileting, dressing, bathing)? Yes\_\_\_ No\_\_\_

If no, please explain: \_\_\_\_\_

\_\_\_\_\_

Write any additional comments regarding this child that may assist in this evaluation:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to child: \_\_\_\_\_