



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
www.ACTSofReading.com**

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: Male _____ Female _____ Transgender M-F _____

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:



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
www.ACTSofReading.com**

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

FAMILY INFORMATION

Biological Father _____ Age _____ Highest grade completed _____

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

Biological Mother _____ Age _____ Highest grade completed _____

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

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

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>



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
www.ACTSofReading.com**

Are there any siblings living outside the home? Yes_____ No_____

If yes, please explain and list names and ages: _____

Have 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: _____



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
www.ACTSofReading.com**

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:



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
www.ACTSofReading.com**

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: _____



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
www.ACTSofReading.com**

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:

		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>



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
www.ACTSofReading.com**

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

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.)?

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



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
www.ACTSofReading.com**

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.

- Inpatient hospitalization
- Outpatient services
- Family-based mental health
- Drug and alcohol services
- Medication management
- Partial hospitalization
- Wraparound services
- Residential treatment facility
- MH/MR case management
- Other:

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: _____



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
www.ACTSofReading.com**

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___

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: _____



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
www.ACTSofReading.com**

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: _____

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: _____



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
www.ACTSofReading.com**

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

Signature of Parent/Guardian: _____

Date: _____

Relationship to child: _____