Maitland Psychology, PA

CHILD INTAKE QUESTIONNAIRE

Name: _____ Date: _____/_____/_____

Name of person completing form and relationship to the patient:_____

Date of Birth: _____/_____/_____ Date of accident, injury, or onset of symptoms: _____/_____/_____

Age: ____ Gender: □ M □ F Handedness: □ Left □ Right

Race/Ethnicity _____ Primary Language (if not English): _____

Referring Physician: _____ Primary Care Physician: _____

Medical Diagnoses (if any): _____

_____

Briefly describe the current concerns: _____

_____

_____

Is there anything that helps reduce the problem(s) or symptom(s)? If so, please describe:_____

_____

Is there anything that seems to make the symptom(s) or problem(s) worse? If so, please describe: _____

_____

Is there any treatment being received? If so, with whom and is it helpful:_____

_____

SYMPTOMS AND CONCERNS

Please check each symptom that applies and add any comments as needed.

Cognitive Concerns

Attention and Concentration

□ Paying attention to things
□ Maintaining concentration
□ Difficulty doing more than one thing at a time
□ Difficulty following instructions or directions
□ Being distracted by his/her own thoughts
□ Being distracted by noises or the environment
□ Becoming easily confused and disoriented
□ Slow thinking speed

Problem Solving and Organization

□ Difficulty solving problems that others could manage
□ Difficulty problem-solving in social situations
□ Difficulty completing an activity in a reasonable time
□ Difficulty doing things in the right order (sequencing)
□ Difficulty organizing items for a project
□ Difficulty changing a plan/activity as needed
□ Difficulty planning steps for a project
□ Difficulty thinking as quickly as needed

Word Finding and Naming

□ Finding the word he/she wants to say
□ Using the wrong words when speaking
□ Forgetting names of family/close friends
□ Forgetting names of acquaintances
□ Difficulty learning new names
□ Difficulty getting speech started

Speech and Language

□ Difficulty understanding what others say
□ Change in the speed of speech
□ Difficulty getting his/her speech started
□ Change in the clarity of speech
□ Change in the complexity of speech
□ Change in volume of speech

Memory

□ Loses or misplaces things
□ Forgets why he/she walked into a room
□ Forgets things than happened hours or days ago
□ Forgets the content of conversation
□ Forgets things that happened months or years ago
□ Forgets if a conversation occurred

Academic Skills

□ Difficulty understanding what is read
□ Difficulty with mental math
□ Difficulty retaining what is read
□ Difficulty with paper and pencil math
□ Difficulty with spelling, grammar or punctuation
□ Difficulty with handwriting

Physical Concerns

Sensory Symptoms

□ Please check if: □ Near-sighted □ Far-sighted □ Astigmatism
□ Blurred vision □ Difficulty with night vision □ Double vision
□ See things that are not there □ Poor peripheral vision □ Color blindness
□ Wear glasses: If so, since what age_____
□ Hearing loss □ Ringing in ears □ Hear strange sounds
□ Problems with taste: If so, Increased/Decreased sensitivity **(Please circle one)**
□ Problems with smell: If so, Increased/Decreased sensitivity **(Please circle one)**
□ Problems with touch (e.g., texture sensitivity) _____
□ Pain (Describe) _____

Motor Symptoms

□ Difficulty with balance □ Difficulty walking □ Fine motor difficulties
□ Tic or strange movements □ Muscle weakness □ Muscle stiffness

Emotional and Behavioral Concerns

Mood/Behavior	**(PLEASE CIRCLE ONE IF APPLICABLE)**		
□ Sadness or depression	Mild	Moderate	Severe
□ Anxiety or nervousness	Mild	Moderate	Severe
□ Anger	Mild	Moderate	Severe
□ Oppositionality	Mild	Moderate	Severe
□ Sleep problems	Falling asleep	Staying asleep	Both

Please indicate if your child has engaged in any of the following behaviors:		
□ Running away from home	□ Breaking and entering	□ Cruelty to animals
□ Stealing	□ Sexual Promiscuity	□ Bullying other children
□ Truancy	□ Fire-setting	□ Destruction of property
□ Tobacco use	□ Illegal substance use	□ Alcohol use

FAMILY HISTORY

Mother: Name_____ Age_____ Education _____

Occupation _____

Father: Name _____ Age_____ Education _____

Occupation _____

Step-Mother: Name _____ Age_____ Education _____

Occupation _____

Step-Father: Name _____ Age_____ Education _____

Occupation _____

Parents are: □ Married □ Separated □ Divorced □ Re-married □ Deceased
Child is: □ Biological □ Adopted □ Foster

Name of Sibling(s)	Age	Gender	Full, Half, Step, or Adopted	Where do they live?

Were there any unusual problems (physical, academic, psychological) associated with any family members?
□ Yes □ No If yes, describe: _____

Who currently lives with the child?_____

Do any family members have significant health concerns/special needs? If so, please explain:_____

_____

Please list any other medical, neurological, or psychiatric conditions that run in the family and the affected family member(s): _____

_____

EDUCATIONAL HISTORY

Current School: _____ Grade: _____

Class Placement: Regular _____ Advanced _____ Special Education _____

Remedial _____ ESOL_____ Other: _____

Has your child ever had an IEP (Individual Educational Plan) or 504 plan? Yes _____ No_____

Please list any grades that were skipped or repeated? _____

Typical grades on report cards? _____

Please check any of the following problems that have been noted by your child's teacher(s):

□ Reading	□ Behavior
□ Writing	□ Social adjustment (getting along with peers)
□ Spelling	□ Attention/Concentration
□ Arithmetic	□ Organization
□ Science/Social Studies	□ Following directions

Additional problems in school: _____

_____

MEDICAL AND TREATMENT HISTORY

Duration of pregnancy: _____ Your child was born through: □ Vaginal Delivery □ Caesarean Section

Please indicate if any of the following situations were present during the delivery of your child:

□ Induced labor	□ Breech position
□ Fetal distress	□ Use of forceps
□ Hemorrhage	□ Cord wrapped around neck

Please indicate if any of the following complications were present during the pregnancy of your child:

□ Excessive vomiting	□ Threatened miscarriage
□ Excessive staining/blood loss	□ Hospitalization
□ Accidents or injuries	□ Toxemia
□ Gestational diabetes	□ Gestational hypertension
□ Smoking/tobacco use	□ Drug use
□ Alcohol use	□ X-rays

Birth weight: _____ APGAR scores (if known): ____ & ____

Was your child cyanotic? (turning blue) _____ No _____ Yes

Please specify any illness/infection present at birth: _____

_____

Please specify any early feeding difficulties: _____

_____

Please select the approximate time of the following developmental milestones:

	Early	On Time/Average	Late
Walking	☐	☐	☐
Language	☐	☐	☐
Toilet training	☐	☐	☐

Please check any of the following problems that your child currently has, or has had in the past:

☐ Seizures	☐ Migraine headaches
☐ Dazed period after a head injury	☐ Aura prior to a migraine headache
☐ Loss of consciousness from head injury	☐ Sensitivity to light or sound with a headache
☐ Permanent changes from a head injury	☐ Nausea or vomiting with a headache
☐ Broken bones from a traumatic event	☐ Sinus headaches
☐ Asthma	☐ Tension headaches
☐ Fever over 104 ˚	☐ Dizziness
☐ Chronic ear infections	☐ Wetting the bed
☐ Grinding his/her teeth	☐ Restless leg syndrome

Please list any food or medication allergies:_____

Please list any surgeries:

Surgery	Month & Year	Results/Success?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all current medical/psychiatric problems and medications taken for each problem (if any)

Medication & Dosage	Frequency Taken	Medical Problem
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please provide any additional information that you feel is relevant to this referral:

_____
_____
_____
_____

Please bring this form with you to your first appointment. All information disclosed is part of your psychological records and thus confidential, as dictated by the Health Insurance Portability and Accountability Act, and the rules and regulations from the State of Florida.