Parent Information Form
Child/Adolescent Intake

Today's Date: _____

Client's First Name: _____ Client's Last Name: _____

Date of Birth: _____ Age: _____

Preferred Pronouns: _____ Sex: _____

Ethnicity: _____

Household Information

Mother's Name _____ Date of Birth_____

Education _____ Occupation _____

Place of Employment _____ Business Phone (____) _____

Father's Name _____ Date of Birth_____

Education _____ Occupation _____

Place of Employment _____ Business Phone (____) _____

Check all that apply:

Parents:			
Married_____	Remarried:	Legal Custody:	Child resides with:
Separated_____	Father_____	Father_____	Father_____
Divorced _____	Mother_____	Mother_____	Mother_____
			Other (specify) _____

Others in the home:

Relation_____ Date of Birth_____ Sex_____

Relation_____ Date of Birth_____ Sex_____

Relation_____ Date of Birth_____ Sex_____

Relation_____ Date of Birth_____ Sex_____

Relation_____ Date of Birth_____ Sex_____

Relation_____ Date of Birth_____ Sex_____

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What specific question(s) do you want answered by this evaluation? Briefly describe the client's current difficulty or difficulties. How long has this area been a concern? What seems to help or make this concern better/worse?

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_____

What are the client's current psychotropic medication name and dose? Please provide a description of current treatment, such as therapy or other services.

_____

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_____

What has been this client's past therapy, treatment (including inpatient hospitalizations), or medications? What age did mental health treatment begin?

_____

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Please describe the client's family history, who raised the client, how many siblings does the client has, include any mental health concerns present or losses within the family.

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Please describe the client's social relationships, including any friendships, romantic, or oversexualized behavior (if present).

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_____

Current School_____ **Current Grade**_____

What is the client's academic and/or vocational performance? Please include any history of support service and special education, as well as any behavioral issues in school.

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What is the client's legal history (if applicable)? Please include any current or past charges and tickets.

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Describe any substance use history or treatment (if applicable).

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Medical History

Child's primary care provider _____

Have you been referred to or consulted with any medical specialists (i.e., neurologists, geneticists, psychiatrists) or other health/educational specialists outside of the school (i.e., psychologists, speech/ language therapists, academic tutors)?

If yes, whom, specialty, dates:

_____

_____

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Does your child have:

Visual problems: _____

Hearing problems: _____

Allergies: _____

Head injuries: _____

Seizures or convulsions: _____

Previous loss of consciousness or coma: _____

Hospitalization for illness: _____

Early Developmental History
Were any of the following present during any part of the child's first two years of life? If so please describe:

Colic or excessive irritability (describe):

_____

_____

_____

Excessive restlessness (describe):

_____

_____

_____

Difficult to calm by being held or consoled (describe):

_____

_____

_____

Problems with sleep (i.e., going to sleep and/or staying asleep):

_____

_____

_____

What were the child's positive characteristics during the first two years of life?

_____

_____

_____

Developmental Milestones

Please indicate the age (in months or years and months) when your child did each of the following:

Smiled_____ Rolled over _____

Sat alone _____ Walked alone _____

Cooed/Babbled _____ Spoke first words _____

Used sentence of 3-4 words _____

Crawling _____ Walking _____

Toilet trained _____ During day _____ Overnight _____

Rode bicycle _____

Recited alphabet _____ Began to read _____

Correctly named 3 colors _____ Began to count _____

What do you view as your child's academic strengths and weaknesses?

_____

_____

_____

Did your child participate in any type of early childhood intervention services?

_____

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Describe your child's **eating** habits: _____

_____

_____

_____

Describe your child's **sleep** habits: _____

_____

_____

_____

Please list any other health/medical problem(s) which you feel may be significant: _____

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If the client has had previous psychological evaluations, please include when these evaluations were completed, by who, and any relevant findings.

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What has been this client's past diagnoses through other sources than psychological evaluations?

_____

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Does the client have any history of physical/sexual abuse or neglect? Are there any other traumatic events, such as witnessing violence, domestic violence, being the victim of a crime, other trauma. If so, please describe.

Please provide any information as to the client's attempts of self-harm, self-injurious behavior, and/or attempts to harm others.

Please describe relevant information as to the client's interests, abilities, and strengths. Also include any spiritual beliefs of importance.

Is there any other information that we should know for this evaluation?

Thank you for completing this packet.