Dr. Susan Meklune

East Brunswick Professional Park

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**INITIAL INTAKE FORM**

Name of person completing this form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child/Adolescent’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_Place of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Culture/Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest Level of Education \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Employment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest Level of Education \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Employment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identified Child/Adolescent Does this child/adolescent have a history of learning, behavioral, or emotional issues? Please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Sibling: Name and Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does this child/adolescent have any history of learning, behavioral, or emotional issues? Please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Sibling: Name and Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does this child/adolescent have any history of learning, behavioral, or emotional issues? Please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Languages spoken in the home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other persons living in the home, please give name(s) and relationship(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If the child is not residing with both parents, please identify person with legal custody, and custody arrangements \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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REASON FOR REFERRAL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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When did you first notice these issues? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has the child had any previous evaluations? If so, where? What was the outcome? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has the child ever been in therapy? If so, where? What was the outcome? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Who referred you? Please list name and address. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your expectation of therapy/evaluation? What are your goals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

PRENATAL HISTORY OF CHILD

If you answer yes to any of the following questions, please describe in the last column.

|  |  |  |  |
| --- | --- | --- | --- |
| QUESTION | YES | NO | DESCRIBE |
| Which pregnancy was this? (include miscarriages) |  |  |  |
| Did you have any illnesses during pregnancy? (colds, measles, infections, operations, accidents?) |  |  |  |
| Did you have any bleeding, spotting, swelling of legs, problems with blood pressure, sugar or protein in urine?  |  |  |  |
| Did you have any physical complaints such as headache, nausea, pain, vomiting, or fatigue? |  |  |  |
| Did you take any medication, drugs, or have any vaccinations during the pregnancy? |  |  |  |
| Did you smoke during the pregnancy? |  |  |  |
| Did you drink alcohol during the pregnancy? |  |  |  |
| Were you concerned with the possibility of a miscarriage? |  |  |  |
| Did you ever have a miscarriage? |  |  |  |
| Were you under a physician’s care during this pregnancy? |  |  |  |

BIRTH HISTORY

Child’s Birthweight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_APGAR Scores \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthweight of other siblings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  QUESTION | YES | NO | DESCRIBE |
| Was the child premature? |  |  |  |
| Were you given anesthesia or medication during childbirth? |  |  |  |
| Was labor induced? |  |  |  |
| Were forceps used? |  |  |  |
| Did you have a caesarian section? If so, why? |  |  |  |
| Were surgical procedures performed during labor? |  |  |  |
| Was this a breech (feet first) delivery? |  |  |  |
| Was the delivery unusual in any way? |  |  |  |
| NEONATAL HISTORY |  |  |  |
|  QUESTION | YES | NO | DESCRIBE |
| Did the infant have any trouble breathing? |  |  |  |
| Did the infant have the cord around the neck? |  |  |  |
| Was the infant blue or yellow? |  |  |  |
| Did the infant have convulsions? |  |  |  |
| Was oxygen given to the infant? |  |  |  |
| Was the infant’s cry absent, weak, or unusual in any way? |  |  |  |
| Did the infant require any special medical care or treatment? |  |  |  |
| Did the infant remain in the hospital following the mother’s discharge? |  |  |  |
| Did the infant appear unusual to you in any way?  |  |  |  |

INFANCY

|  |  |  |  |
| --- | --- | --- | --- |
|  QUESTION | YES | NO | DESCRIBE |
| Did the baby have a weak suck? |  |  |  |
| Was the baby a slow feeder? |  |  |  |
| Did the baby lose a lot of formula during feeding? |  |  |  |
| Did the baby spit up frequently? |  |  |  |
| Did the baby resist being held or fondled? |  |  |  |
| Was the baby overly responsive or sensitive to noise or sound? |  |  |  |
| Was the baby very active? |  |  |  |
| Was the baby irritable? |  |  |  |
| Did the baby demonstrate very little physical activity? |  |  |  |
| Did the baby have sleeping difficulties?  |  |  |  |

BEHAVIOR AND SOCIALIZATION

|  |  |  |  |
| --- | --- | --- | --- |
|  QUESTION | YES | NO | DESCRIBE |
| Does the child band hand or engage in rocking movements? |  |  |  |
| Is the child extremely active? |  |  |  |
| Is the child very withdrawn? |  |  |  |
| Is the child very clumsy? |  |  |  |
| Does the child stutter? |  |  |  |
| Is the child more interested in things than people? |  |  |  |
| Does the child understand what is being said to him/her? |  |  |  |
| Does the child have temper tantrums? |  |  |  |
| Does the child have any unusual behavior? Mannerisms? |  |  |  |

DEVELOPMENTAL MILESTONES

|  |  |  |
| --- | --- | --- |
|  SKILL | AGE ACCOMPLISHED  | NOT YET ACCOMPLISHED |
| Motor: Held head up |  |  |
| Rolled over |  |  |
| Sat alone |  |  |
| Crawled |  |  |
| Took steps holding on |  |  |
| Walked alone |  |  |
| Rode tricycle |  |  |
| Buttoned clothing independently |  |  |
| Rode bicycle |  |  |
| Handedness: right\_\_\_ left \_\_\_ |  |  |
| Social: Smiled spontaneously |  |  |
| Smiled responsively |  |  |
| Played interactively |  |  |
| Recognized mother |  |  |
| Showed shyness with others |  |  |
| Played simple games (pee-a-boo) |  |  |
| Language: Babbled  |  |  |
| Said “Mama” or “Dada” |  |  |
| Skill | Age Accomplished | Not Yet Accomplished |
| Used 2 or 3 word sentences |  |  |
| Understood “no” |  |  |
| Understood what is being said |  |  |
| Feeding: held cookie and chewed |  |  |
| Weaned from breast or bottle |  |  |
| Chewed table foods |  |  |
| Finger fed self |  |  |
| Held and drank independently from cup |  |  |
| Fed self with spoon |  |  |
| Toileting: Discomfort from wet/soiled diaper |  |  |
| Expressed desire to have diaper changed |  |  |
| Bowel trained |  |  |
| Bladder control: Daytime |  |  |
| Bladder control: Nighttime |  |  |
| Went independently to bathroom |  |  |
| Does child wet the bed now? |  |  |
| Does child soil pants now? |  |  |

Health History

|  |  |  |  |
| --- | --- | --- | --- |
| Question | Yes | No | Describe |
| Mumps |  |  |  |
| Chicken Pox |  |  |  |
| Measles |  |  |  |
| Whooping Cough |  |  |  |
| German Measles |  |  |  |
| Scarlet Fever |  |  |  |
| High Fever |  |  |  |
| Asthma |  |  |  |
| Seizures or convulsions |  |  |  |
| Headaches or dizziness |  |  |  |
| Skin disease or abnormality |  |  |  |
| Question | Yes | No | Describe |
| Birthmarks |  |  |  |
| Eye or vision problems |  |  |  |
| Ear or hearing problems |  |  |  |
| Speech problems |  |  |  |
| Foot problems |  |  |  |
| Allergies (food, drug, etc.) |  |  |  |
| Accidents |  |  |  |
| Operations |  |  |  |
| Hospitalizations |  |  |  |

Hearing

Has your child ever had an audiological evaluation? If so, what were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have ear infections or other ear medical issues? If so, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Has your child ever had tubes in his ears? If so, when and how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there a history of speech and/or hearing issues in your family? If so, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |  |  |  |
| --- | --- | --- | --- |
| Question | Always  | Sometimes | Never |
| Do you need to repeat yourself when speaking with your child? |  |  |  |
| Does your child have poor tolerance to loud sounds? |  |  |  |
| Is it difficult for your child to tell where a sound is coming from? |  |  |  |
| Does your child have poor articulation? |  |  |  |
| Do other people have difficulty understanding your child’s speech? |  |  |  |

Medications

Is your child on medication? If so, please complete the following.

|  |  |  |
| --- | --- | --- |
| Medication Taken | Dose | Reason |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**PSYCHIATRIC HISTORY**

Was your child ever in mental health therapy? If so, when? What was the issue? How long?

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What are/were the results of treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Was your child ever hospitalized for mental health issues? Had any suicide attempts? If so, please provide dates.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Educational History

Please list all schools your child has attended to date. Please include pre-school.

|  |  |  |  |
| --- | --- | --- | --- |
| Name of School | Location | Dates of Attendance | Problem/Issues |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Has your child has any of the following services in school? If yes, please describe.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Service | No | Yes | When/Where | Reason |
| Early Intervention |  |  |  |  |
| Speech Therapy |  |  |  |  |
| Remedial Class (Basic Skills,etc.) |  |  |  |  |
| Special Education services |  |  |  |  |
| Other services (physical, occupational therapy |  |  |  |  |

Family Medical History.

Please indicate if any family member have had any of the following medical issues. Include parents, siblings, aunts, uncles, cousins, and grandparents.

|  |  |  |  |
| --- | --- | --- | --- |
| Question | Yes | No | Describe |
| Seizures or epilepsy |  |  |  |
| Deafness |  |  |  |
| Blindness |  |  |  |
| Cognitive Impairment |  |  |  |
| Poor coordination |  |  |  |
| Speech issues |  |  |  |
| Physical difficulties |  |  |  |
| Reading difficulties |  |  |  |
| Emotional difficulties |  |  |  |
| Other conditions  |  |  |  |

Other Family Events

|  |  |  |  |
| --- | --- | --- | --- |
| Question | Yes | No | Describe |
| Adoption |  |  |  |
| Marital Issues/Problems |  |  |  |
| Divorce |  |  |  |
| Long absence/illness of important family member or close friend |  |  |  |
| Change of residence |  |  |  |
| Serious physical illness/accident |  |  |  |
| Death of family member or close friend |  |  |  |
| Other significant event  |  |  |  |

Child’s Social History

|  |  |  |  |
| --- | --- | --- | --- |
| Question | Yes | No | Describe |
| Does your child have a best friend? |  |  |  |
| Does your child currently interact with other children in school? |  |  |  |
| Is your child dating? If so, how long has the relationship been going on? |  |  |  |
| What is your child’s favorite social activity?  |  |  |  |

Please use the bottom of this form to write about any other issue or events that might be relevant to this initial assessment.

Thank you for completing this intake form.