NewVu THERAPY
7777 Glades Road Suite 205
Boca Raton, FL 33434
(561) 613-5217

CLIENT INTAKE – CHILD (0-6 YEARS)

1. Identifying & Family Information

Child Name:_____ Date of Birth:____/____/____

Age: _____ Sex: _____ Diagnosis (if any): _____

How were you referred to NewVu? _____

Parent/Guardian Name(s): _____

Parent/Guardian Occupation(s): _____

Address: _____

Phone: (Cell)_____(Work)_____(Other) _____

Child Lives With: _____ Mother _____Father _____Stepmother _____Stepfather _____Relatives

Fostered _____Adopted_____

Parents: _____currently together _____ separated _____ divorced _____ deceased _____ other

Siblings: Name: _____ Age: _____ Sex: _____ Grade: _____

Name: _____ Age: _____ Sex: _____ Grade: _____

Name: _____ Age: _____ Sex: _____ Grade: _____

Child's Race/Ethnicity: _____ Caucasian, Non-Hispanic _____ Hispanic _____ Asian

_____ African American _____ Other (_____)

2. Medical History

Doctor's Name: _____Phone/City: _____

Hearing/vision issues? _____Allergies: _____

Date of last physical: _____ Dental problems? _____

Current medications: _____Operations, illness, accidents:_____

Has your child had any of the following? (Check all that apply and indicate approximate age)

_____ Seizures _____ Breathing difficulties _____ Head injury

_____ Frequent colds _____ Ear tubes _____ Asthma

List all recent evaluations and medical treatments your child has received (Neurologist Occupational Therapist, Dietician, Speech-Language Pathologist, Allergist, Physical Therapist, Tutor, etc.):

Professional Name & Title	Date of Eval/Treatment	Outcome/Goals

3. Nutrition

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Current Supplements/Vitamins: _____

Dietary Restrictions: _____

Typical Diet: _____

4. Family History

In the child's family is there, or has there ever been, any of the conditions listed on the following checklist?

CONDITION	RELATIONSHIP/Paternal or Maternal	FURTHER INFORMATION
Psychiatric Issues (i.e. Bipolar, Schizophrenia)		
Depression or Anxiety		
ADD/ADHD		
Learning Disabilities		
Alcohol or Drug Issues		
Legal Issues or Arrests		

5. Developmental History

Prenatal and Perinatal period

Was the pregnancy planned? _____ How did parents feel about the pregnancy? _____

Did mother receive prenatal care? Yes No Duration of pregnancy: _____ weeks

Any medications, drugs, or alcohol taken during pregnancy? _____

How did mother feel during the pregnancy? Any sickness? _____

Anything unusual about pregnancy or birth? _____

How did mother feel after birth? Any post-partum depression/anxiety? _____

Labor was: _____ Difficult _____ Easy _____ Prolonged

Delivery was: _____ Vaginal _____ Cesarean _____ Forceps _____ Suction/Vacuum

Birth weight: _____Birth length: _____ Age of Mother at birth: _____Father: _____

Was the baby unusually: Fussy: Yes No Colicky: Yes No Quiet: Yes No

Feeding History

Breast-fed for how long? _____ Bottle-fed for how long? _____

Any feeding problems? _____When was child weaned? Why? _____

Sleeping History

Were or are there any sleep problems? _____Current sleeping arrangements: _____

Oral Habits

Did your child use a pacifier? _____ Age weaned: _____ Difficulty weaning? _____

Does your child suck any of the following: _____ fingers _____ blanket _____ shirt
_____ tongue _____ other

Did/does you child have other oral habits? _____ teeth grinding _____ pencil biting
_____ nail biting _____ other (_____)

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Infant period: 0-18 months. Circle yes or no. If yes, provide explanation.

High Fever?	Yes	No	_____
Cried often or difficult to soothe?	Yes	No	_____
Strikingly sluggish, inactive?	Yes	No	_____
Frequent ear infections?	Yes	No	_____
Difficulty sleeping?	Yes	No	_____

Developmental Milestones: At what age did your child…

Sit up	_____	Point with index finger	_____
Crawl	_____	Babble	_____
Grasp small objects (cheerios)	_____	Say first words	_____
Walk	_____	Use 3-4 word phrases	_____

Which of the following is most typical of your child's ability to understand speech? (Circle one):

a. Does not understand what is said.
b. Understands very little of what is said.
c. Better understands what is said with gestures.
d. Understands familiar statements or questions.
e. Understands most things that are said.
f. Understands clearly everything that is said.

Childhood: 18 months – 9 years. Circle yes or no. If yes, provide explanation.

Problems learning to hold a pen/pencil?	Yes	No	_____
Problems learning to write?	Yes	No	_____
Sensitivity to: clothing?	Yes	No	_____
sounds?	Yes	No	_____
other (textures, smell, etc.)?	Yes	No	_____

Was toilet training easy or difficult? _____

Age stayed dry at night _____ Age toileted on own _____

6. Educational History

Current (or most recent) School/Daycare: _____

Current Grade/Group: _____ Primary Teacher(s)/Caregiver(s): _____

Did child attend preschool or nursery school? _____ If yes, what ages? _____

How does your child feel about school/daycare and teacher(s)/caregivers? _____

Describe your child's behavior and performance in school/daycare including strengths and weaknesses.

7. History of Difficulty

Small spaces have been provided for responses. Feel free to use the back of each page for additional space and indicate when doing so by writing "over" next to the question.

What prompted you to seek help now?

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When your child misbehaves or engages in actions that are unacceptable to you, what methods of discipline have you used? Describe how and when you use the method and how successful it is or was.

Describe and rank your top 2 short-term goals for your child (i.e. behavioral, academic, social, emotional, etc.). What is your top long-term goal for your child? (Please be as specific as possible.)

Tell me about any recent stresses, changes, or crises in your family and when they occurred. (i.e. working longer hours, family conflict, relocation, death/loss, relationship ended)

8. Emotional & Behavioral Health

Has your child ever seen a psychotherapist, psychologist, or psychiatrist? _____
If so, what did you and he/she like and dislike about it? _____
What was the outcome of the treatment or evaluation? _____
Please check any of the following that apply to your child:

_____ Cooperative	_____ Restless	_____ Attentive	_____ Inattentive
_____ Hyperactive	_____ Aggression	_____ Head banging	_____ Fearful
_____ Tantrums	_____ Stubborn	_____ Impulsive	_____ Withdrawn
_____ Self-injurious	_____ Destructive	_____ Compulsions/rituals	_____ Shy
_____ Separation difficulty	_____ Irritable	_____ Reflux	_____ Stomachaches
_____ Headaches	_____ Defiant	_____Willing to try new activities	

How does your child handle new challenges and changes that occur? What is your child's response to stress?

Please describe any kinds of self-soothing or "tuning out" behaviors in which your child engages (i.e. hiding, rubbing, rocking, hand flapping, singing, humming, etc.)

Describe any fears, anxieties, or aversions attached to certain situations, people, objects, being touched, foods.

Describe any of your child's regular rituals, routines, compulsive behaviors, or repetitive thoughts and ideas.

11. Social History

Child gets along best with: _____ Peers _____ Siblings _____ Younger children
_____ Older children _____ Adults _____ Other (_____)

Does your child have a friend(s) or playmate(s)? _____

Can your child independently stay with a group? Yes No

Does your child prefer to play alone? Yes No

How interested is your child in social interaction? _____

What are your child's interests and hobbies? _____

Please add information or questions that you believe are important on the back of this page.