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

CLIENT INTAKE – CHILD & ADOLESCENT

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: ____

Major 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

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3. Nutrition

Current Supplements/Vitamins: ____________________

Dietary Restrictions: ____________________

Typical Diet

Breakfast: ____________________

Lunch: ____________________

Snacks: ____________________

Dinner: ____________________

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? ____________________

Was your child exposed to any drugs or alcohol in utero? ____________ Premature? __________ Breast-fed? __________

Did the mother experience any post-partum issues, depression, anxiety?

Anything unusual about pregnancy or birth? ____________________

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

Were or are there any sleep problems? ____________________

Has child ever slept with parents? ____________________

Current sleeping arrangements: ____________________

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

High Fever?	Yes	No	________
Easily frustrated?	Yes	No	________
Cried often or difficult to soothe?	Yes	No	________
Strikingly sluggish, inactive?	Yes	No	________

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Frequent ear infections? Yes No ________________________
Difficulty sleeping? Yes No ________________________

Developmental Milestones: At what age did your child…

Sit up ________ Crawl ________ Walk ________ Talk ________

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 ride a bicycle?	Yes	No	____________
Problems learning to read?	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: ____

Current Grade:________Primary Teacher(s): ________________________________

How are your child's grades? _________________ IEP/programs? ________________

How does your child feel about school? ________________________________

How does your child feel about the teacher(s)?________________________________

Describe your child's school performance including strengths and weaknesses.

7. History of Difficulty

Small spaces have been provided. Feel free to use the back of each page for additional space and write "over" next to the question.

What prompted you to seek help now? Describe your child's present difficulties at home and/or in school as you view them.

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 3 short-term goals for your child (i.e. behavioral, academic, social, emotional,

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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, when they occurred, and how you think it may have affected your child, yourself, or the family. (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:

_____ Argumentative	_____ Defiant	_____ Inattentive	_____ Anxious
_____ Physical Aggression	_____ Hyperactive	_____ Tearful/Sad	_____ Fearful
_____ Tantrums/Outbursts	_____ Stubborn	_____ Impulsive	_____ Withdrawn
_____ Difficulty focusing	_____ Shy	_____ Compulsions/Rituals	_____ Self-harm
_____ Irritable/Moody	_____ Stomachaches	_____ Headaches	_____ Nightmares
_____ Appetite Change	_____ Sleep Change	_____ Lying	_____ Illegal Activity
_____ Suicidal Thoughts	_____ Suicidal Threat	_____ Low Motivation	_____ Manipulative

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

Please describe any strange or unusual behaviors displayed by the child. Include any strange thoughts and ideas, seizure or tic-like behaviors, etc.

9. Social History

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

Does your child have close friend(s)?____

How do you feel about his/her friends? ____

How interested is your child in social interaction? ____

What are your child's interests and hobbies? How do they spend their free time?__________________

____

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