CHILD & ADOLESCENT INTAKE INFORMATION

Child's Name_____ Date_____

Address_____ Home Phone ( )_____

_____ Birth Date_____ Age_____

Grade _____ Religion_____

_____

Family (If parents home address and phone is same as child's just write "same")

Father's Name_____	Mother's Name_____
Birth Date_____ Age_____	Birth Date_____ Age_____
Marital History_____	Marital History_____
Education_____	Education_____
Occupation_____	Occupation_____
Religion _____	Religion _____
Ethnic Group _____	Ethnic group _____
Address_____	Address_____
_____	_____
Home Phone ( )_____	Home Phone ( )_____
Work Phone ( )_____	Work Phone ( )_____

Siblings & Others in Household

Name	Relationship	Age	Birth Date	Education

Emotional and Social Adjustment

1. How would you describe your child's personality?_____

_____

2. Specifically, what are the problems presented by your child? _____

_____

_____

_____

3. Which of these concerns you most? _____

4. When were these problems first noted? _____ By whom? _____

5. Does your child demonstrate any awareness of these problems? _____ If yes, explain _____

_____

6. Which problems seem to concern your child most? _____

_____

7. Describe your child's relationship with his immediate family (mother, father, siblings, etc.)._____

_____

_____

_____

8. Describe your child's relationship with other adults (including teachers)._____

_____

_____

9. Describe any exposure your child has had to domestic violence, physical and/or sexual abuse:_____

_____

_____

10. Has your child ever had any unusual emotional reactions, habits, rituals, difficulty separating or fears? _____

If yes describe:_____

_____

General Medical Information

1. Name of child's Physician _____ Phone # _____

Address _____ Date of last physical _____

_____

2. Is your child receiving any medication at present? _____ (If yes, please list the type of drug, dosage if known, date started, purpose, and any adverse reactions to the drugs.)

Drug	Dosage	Date started	Purpose	Reaction

3. Previous illnesses injuries or surgeries (please list the age at time of each, *yes or no* if hospitalized, and approximate # of days in hospital)

Illness	Age	Hospitalized?	Length

4. Asthma, eczema or allergies? _____ If yes, describe frequency, severity, & treatment:_____

_____

5. Has your child had any adverse reactions to any drugs taken in the past? _____ If yes please explain:_____

_____

_____

6. Does your child have a history of fainting, convulsions or seizures? _____ Date of last occurrence:_____

Are these currently controlled by medication?_____ Explain:_____

_____

9. Does your child have any physical handicaps? _____ If yes please describe:_____

_____

_____

10. Has your child had a visual examination?_____ If yes by whom?_____

Date of last exam:_____Does your child wear corrective lenses?_____Is your child nearsighted?_____Farsighted?____

11. Has your child had a hearing examination?_____ If yes by whom?_____

Date of last exam:_____Does your child have a hearing loss?_____If so how severe (mild, moderate, or severe)?

Right ear_____Left ear_____Does your child wear an aide?_____

12. Does your child have a speech difficulty?_____If yes describe the difficulty:_____

_____

Speech therapy?_____If yes by whom?_____Inclusive dates:_____

13. Has your child had a neurological evaluation?_____By whom?_____

Address:_____

Reason for examination:_____Inclusive dates:_____

14. Has your child ever had a psychiatric evaluation?_____By whom?_____

Address:_____

Reason for evaluation:_____Inclusive dates:_____

15. Has your child had a psychological evaluation?_____By whom?_____

Address:_____

Reason for evaluation:_____Inclusive dates:_____

16. Has your child ever received any previous counseling, psychotherapy, or other mental health treatment?_____

If yes please list the **name, address, and inclusive dates seen** for each provider:_____

_____

_____

_____

_____

17. Has either parent ever received any previous counseling, psychotherapy, or other mental health treatment?_____

If yes please list the **name, address, and inclusive dates seen** for each provider: _____

_____

_____

Developmental History

1. Full term pregnancy?_____ Normal Birth?_____ Length of labor:_____

   Were forceps used?_____ APGAR score:_____

   Any complications before, during or immediately after delivery?_____If yes, describe:_____

   _____

2. Describe mother's health during pregnancy with this child, including whether X-rays or drugs were received and why:_____

   _____

   _____

3. Did mother smoke, use alcohol and /or drugs during pregnancy? _____ If yes please describe amounts and frequency:_____

   _____

4. Were there any feeding problems?_____ If so, describe:_____

   _____

   At what age was weaning achieved?_____ Are there any eating problems now?_____ If so, describe:_____

   _____

5. Any colic or early management problems?_____

   _____

6. At what age did your child creep?_____ Stand with support?_____ Walk?_____

7. Has your child been excessively active?_____ Does your child seem poorly coordinated (awkward, clumsy)?_____

   If so, describe:_____

   _____

8. At what age did your child speak their first word?_____ Phrases?_____ Sentences?_____

9. At what age was toilet training achieved for bladder?_____ For bowel?_____ Has your child ever experienced any problems with elimination? (soiling, wetting, or bed wetting)_____ If so, describe:_____

_____

10. At what age did your child first sleep through the night?_____ Have there ever been any problems with sleep? (nighmares sleepwalking, difficulties falling asleep, etc)_____ If so, describe:_____

_____

11. Compared with other children, do you consider your child to be small, average, or big in size for his/her age?_____

School History

1. Did your child attend preschool?_____ If so list age started and years attended:_____

_____

2. If your child is school age please list the following: (start with K & end with current school placement)

Name of School Attended	City & State	Grade(s)	Inclusive dates

3. If any grade has been repeated, indicate which grade and why:_____

_____

4. Have there been frequent absences from school?_____ If so, why?_____

_____

5. Describe your child's attitude towards school._____

6. Does your child discuss with you his/her school activities, progress and /or difficulties?_____

7. Is there any difficulty with school subjects?_____ If so indicate what subjects, when first noted, and by whom:_____

_____

_____

8. Has your child had any tutoring or remedial work?_____ If so indicate subject, how often, and grades:_____

_____

_____

9. Has there been any difficulty with behavior in school?_____ If so, describe: (behavior, grade(s) occurred in, & how handled)_____

_____

_____

_____

_____

_____

Who referred you to this practice?_____

May I contact this person in order to thank them for the referral and let them know you followed through?_____

The information on this form was supplied by:_____

11/1/96

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Allentown, PA 18104-6116
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Fax (610) 841-4967

Child Checklist of Characteristics

Name:_____ Date:_____

Age:_____ Person completing this form:_____

Please mark all of the items that apply to your child. Feel free to add any others at the end under "Any other characteristics."

- ☐ Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Child management, parenting
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use—prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pains
- ☐ Health, illness, medical concerns, physical problems
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Loneliness
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness

(over for page 2)

- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems
- ☐ School problems (see also "Career concerns . . .")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, other (see also "Abuse")
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems—too much, too little, insomnia, nightmares
- ☐ Smoking and tobacco use
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts
- ☐ Temper problems, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Affectionate
- ☐ Argues, "talks back," smart-alecky, defiant
- ☐ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- ☐ Cheats
- ☐ Cruel to animals
- ☐ Concern for others
- ☐ Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
- ☐ Complains
- ☐ Cries easily, feelings are easily hurt
- ☐ Dawdles, procrastinates, wastes time
- ☐ Difficulties with parent's paramour/new marriage/new family
- ☐ Dependent, immature
- ☐ Developmental delays
- ☐ Disrupts family activities
- ☐ Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
- ☐ Distractible, inattentive, poor concentration, daydreams, slow to respond
- ☐ Dropping out of school
- ☐ Drug or alcohol use
- ☐ Eating—poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- ☐ Exercise problems
- ☐ Extracurricular activities interfere with academics
- ☐ Failure in school
- ☐ Fearful
- ☐ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- ☐ Fire setting
- ☐ Friendly, outgoing, social
- ☐ Hypochondriac, always complains of feeling sick
- ☐ Immature, "clowns around," has only younger playmates
- ☐ Imaginary playmates, fantasy
- ☐ Independent
- ☐ Interrupts, talks out, yells

(continue to page 3)

- ☐ Lacks organization, unprepared
- ☐ Lacks respect for authority, insults, dares, provokes, manipulates
- ☐ Learning disability
- ☐ Legal difficulties—truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- ☐ Likes to be alone, withdraws, isolates
- ☐ Lying
- ☐ Low frustration tolerance, irritability
- ☐ Mental retardation
- ☐ Moody
- ☐ Mute, refuses to speak
- ☐ Nail biting
- ☐ Nervous
- ☐ Nightmares
- ☐ Need for high degree of supervision at home over play/chores/schedule
- ☐ Obedient
- ☐ Obesity
- ☐ Overactive, restless, hyperactive, out-of-seat behaviors, restlessness, fidgety, noisiness
- ☐ Oppositional, resists, refuses, does not comply, negativism
- ☐ Prejudiced, bigoted, insulting, name calling, intolerant
- ☐ Pouts
- ☐ Recent move, new school, loss of friends
- ☐ Relationships with brothers/sisters or friends/peers are poor—competition, fights, teasing/provoking, assaults
- ☐ Responsible
- ☐ Rocking or other repetitive movements
- ☐ Runs away
- ☐ Sad, unhappy
- ☐ Self-harming behaviors—biting or hitting self, head banging, scratching self
- ☐ Speech difficulties
- ☐ Sexual—sexual preoccupation, public masturbation, inappropriate sexual behaviors
- ☐ Shy, timid
- ☐ Stubborn
- ☐ Suicide talk or attempt
- ☐ Swearing, blasphemes, bathroom language, foul language
- ☐ Temper tantrums, rages
- ☐ Thumb sucking, finger sucking, hair chewing
- ☐ Tics—involuntary rapid movements, noises, or word productions
- ☐ Teased, picked on, victimized, bullied
- ☐ Truant, school avoiding
- ☐ Underactive, slow-moving or slow-responding, lethargic
- ☐ Uncoordinated, accident-prone
- ☐ Wetting or soiling the bed or clothes
- ☐ Work problems, employment, workaholism/overworking, can't keep a job

Any other characteristics:

- ☐ _____
- ☐ _____
- ☐ _____

Please look back over the concerns you have checked off and choose the one that you most want your child to be helped with. Which is it? _____

S.W. corner of Hamilton & Miller Sts.

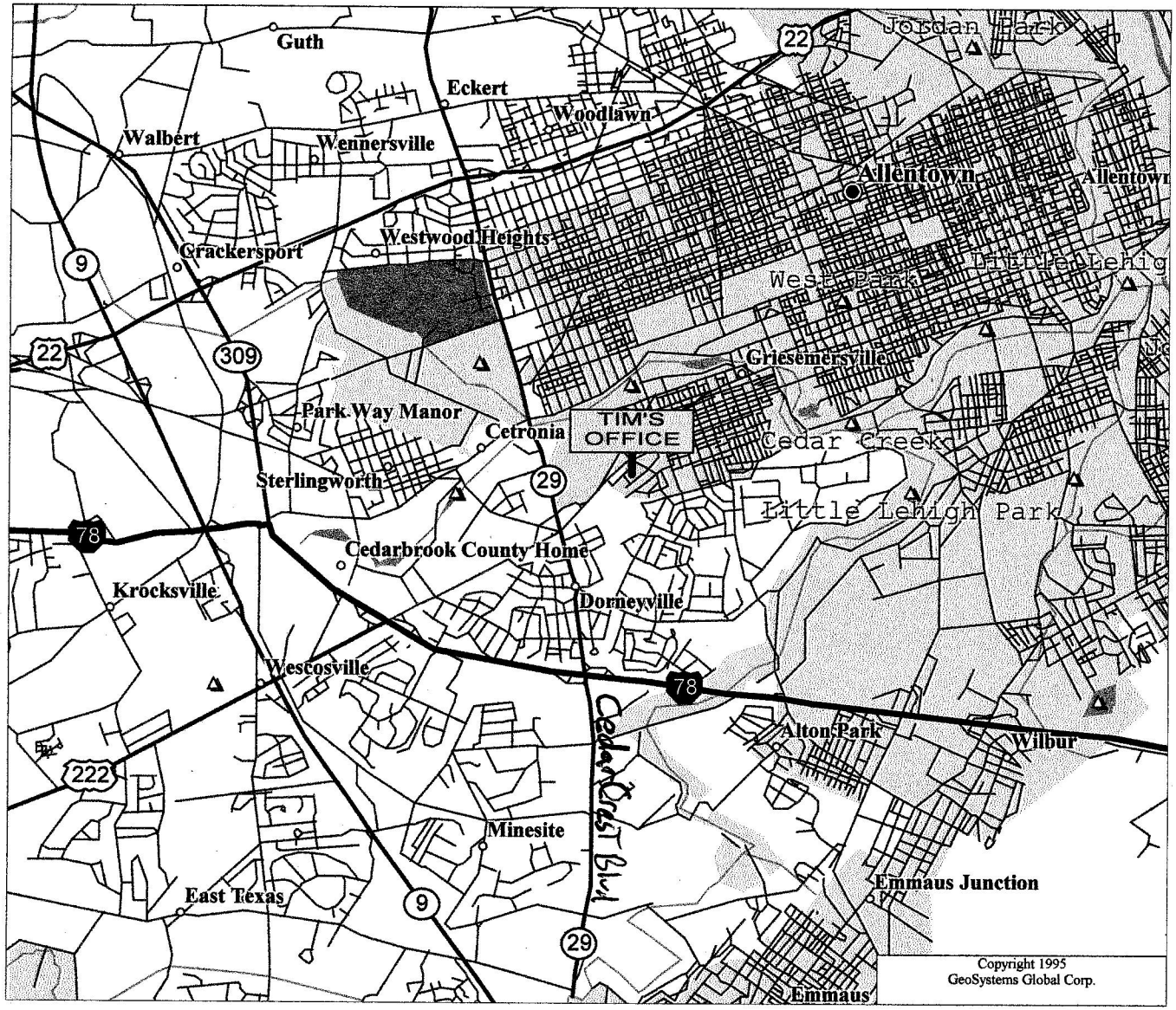
Please Park on Miller St.

Primary Road
Secondary Road
Minor Road
Park
Water
Built Up Area

0.11 mile

Compton's Complete Street Guide

Tim's Office - 2806 Hamilton Blvd.



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