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Licensed Psychologist

Intake and Developmental History – Child

Today's Date: _____
Child's Name: _____ Date of Birth: _____ Age: _____
Person Completing this Form: _____

Identifying Information
Child's School:_____ Grade:_____ Teacher: _____

Reason for Referral: _____
_____
_____
_____
_____
_____
_____

Mother's name: _____ Birthdate: _____
Home phone: _____ Cell Phone: _____ May I leave messages? _____
Address: _____
Currently employed outside the home? ❑ No ❑ Yes, as: _____

Father's name: _____ Birthdate: _____
Home phone: _____ Cell Phone: _____ May I leave messages? _____
Address: _____
Currently employed outside the home? ❑ No ❑ Yes, as: _____

Parents are currently ❑ Married ❑ Divorced ❑ Remarried ❑ Never married
❑ Other: _____
Child's custodian/guardian is: _____

Stepparent's name: _____ Birthdate: _____
Home phone: _____ Cell Phone: _____ May I leave messages? _____
Address: _____
Currently employed outside the home? ❑ No ❑ Yes, as: _____

Siblings? Names and Ages: _____
_____

Family Background

Is there any family history of developmental, learning, attentional, emotional, behavioral, social, or mental health concerns? If so, please describe: _____

_____

_____

_____

_____

Have there been any recent changes in family composition or significant family life events (such as divorce, death in the family, birth of a sibling, move to a new home, changing of schools, etc.)? If so, please describe:

_____

_____

_____

_____

Developmental History

Pregnancy and Delivery:

Please describe any pregnancy complications and medications taken during pregnancy: _____

_____

_____

Was the child born full-term? ❑ No ❑ Yes

Weight and height at birth: _____ pounds _____ inches

Any birth complications or problems? _____

_____

First few months of life:

Please describe the child's personality during infancy:_____

_____

_____

Sleep habits or problems?: _____

_____

_____

Developmental Milestones:

At what age did the child do each of these?

Sit without support: _____
Crawl: _____
Walk without holding on: _____
Help when being dressed: _____
Tie shoelaces: _____
Button buttons: _____
Eat with a fork: _____
Stay dry all day: _____
Stay dry all night: _____
Age when child said first word understandable to a stranger: _____
Age when child said first sentence understandable to a stranger: _____
Any speech, hearing, or language difficulties? _____

_____

_____

Does the child now or did the child ever receive Birth-to-Three Services? If so, please describe concerns and list services received and approximate dates:

_____

_____

_____

_____

_____

_____

_____

Does the child now or did the child ever receive Preschool Special Education Services? If so, please describe concerns and list services and approximate dates.

_____

_____

_____

_____

_____

_____

_____

Medical History

Has the child been admitted to the hospital at all since birth? ❑ No ❑ Yes
If yes, at what age and why? _____

Have there been any illnesses or injuries other than the usual childhood diseases? ❑ No ❑ Yes
If yes, please describe: _____

Does your child have any allergies? ❑ No ❑ Yes
If yes, please describe: _____

Does your child currently take any medications? ❑ No ❑ Yes
If yes, please list medications, dosages, and prescribing physician:
_____
_____
_____

Has your child taken medication in the past? ❑ No ❑ Yes
If yes, please list medications, dosages, prescribing physician, and reason for discontinuation:
_____
_____
_____

Most recent vision and hearing screening and results: _____
_____
_____

Educational History

Nursery School/Pre-K:
Did your child go to nursery school or pre-k? ❑ No ❑ Yes
If so, where? _____
Ages or dates attended _____
Pertinent information relating to preschool experiences _____
_____
_____
_____
_____
_____

Elementary, Middle, and High School:
School (name, location) Grade Teacher

Does your child now, or did your child ever, receive special education services at school? ❑ Yes ❑ No
(If yes, please provide a copy of current IEP or 504 plan and most recent evaluation(s))

If your child has an IEP, under what educational category does he or she receive services? _____

What IEP or 504 services did/does your child receive? _____
_____
_____
_____
_____
_____
_____
_____

Socialization

Are your child's playmates ❑older? ❑younger? ❑same age?
Does your child make friends easily? ❑Yes ❑No
Does your child prefer to play ❑ alone? Or ❑ with others?
Describe your child's relationship with brothers and sisters. _____
_____
_____
What are your child's favorite toys and play activities? _____
_____
_____

What are your child's hobbies, favorite sports, favorite TV shows, etc? _____
_____
_____
What are your child's favorite activities with parents? _____
_____
_____

Other Evaluations and Services

Has your child been evaluated previously? ❑ Yes ❑ No (If yes, please provide copies of prior evaluations)
Evaluator Date

Does your child receive services outside of school (such as OT, PT, Speech, social skills support, behavior support)? ❑ Yes ❑ No
Service Date(s)

Has your child received services outside of school in the past? ❑ Yes ❑ No

Service Date(s)

Additional Remarks or Information

_____
_____
_____
_____
_____
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_____
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_____