



## Child Intake Form

### IDENTIFYING INFORMATION

Child's Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_ Religious affiliation: \_\_\_\_\_

Person completing this form: \_\_\_\_\_ Today's date: \_\_\_\_\_

How did you hear of Dr. Jennie? \_\_\_\_\_

Child's custodian/guardian(s) is/are: \_\_\_\_\_

Child's home address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home telephone: \_\_\_\_\_

Best email to reach the family at? \_\_\_\_\_

Can we contact you by email to let you know about groups or other updates about the clinic? Yes No

Would you like to receive appointment confirmations by email? Yes No

Do you have Extended Health Care Insurance? Yes No Insurance Company Name: \_\_\_\_\_

Extended Health Care Insurance #: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

City: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### MOTHER'S (GUARDIAN) INFORMATION

Mother's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Home or cell phone: \_\_\_\_\_

Address: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_ Religious affiliation: \_\_\_\_\_

Highest level of education: \_\_\_\_\_

Marital/relationship status (Check one)

Married: Living with Partner: Single: Separated/Divorced: Widowed: or Other:

If separated or divorced, do you have a court custody agreement? Yes No

*(If yes, a copy of this document is required at the time this intake form is returned)*

Employment status (check all that apply)

Employed: Retired: Disabled: Student: Homemaker: Unemployed:

If/When employed, what type of work does mother do? \_\_\_\_\_

Current employer is: \_\_\_\_\_

Years on current job: \_\_\_\_\_ Business Phone: \_\_\_\_\_



FATHER'S (GUARDIAN) INFORMATION

Father's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Home or cell phone: \_\_\_\_\_
Address (if different from the mother's): \_\_\_\_\_
Race/Ethnicity: \_\_\_\_\_ Religious affiliation: \_\_\_\_\_
Highest level of education: \_\_\_\_\_

Marital/relationship status (Check one)

Married: Living with Partner: Single: Separated/Divorced: Widowed: or Other:

If separated or divorced, do you have a court custody agreement? Yes No
(If yes, a copy of this document is required at the time this intake form is returned)

Employment status (check all that apply)

Employed: Retired: Disabled: Student: Homemaker: Unemployed:

If/When employed, what type of work does father do? \_\_\_\_\_

Current employer is: \_\_\_\_\_

Years on current job: \_\_\_\_\_ Business phone: \_\_\_\_\_

STEP-PARENT'S INFORMATION

Step-parent's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Home or cell phone: \_\_\_\_\_
Address: \_\_\_\_\_
Race/Ethnicity: \_\_\_\_\_ Religious affiliation: \_\_\_\_\_
Highest level of education: \_\_\_\_\_

Marital/relationship status (Check one)

Married: Living with Partner: Single: Separated/Divorced: Widowed: or Other:

Employment status (Check all that apply)

Employed: Retired: Disabled: Student: Homemaker: Unemployed:

If/When employed, what type of work does step-parent do? \_\_\_\_\_

Current employer is: \_\_\_\_\_

Years on current job: \_\_\_\_\_ Business phone: \_\_\_\_\_

Is it OK to contact step-parent at work? Yes No Is it OK to leave a message? Yes No

Special calling instructions? \_\_\_\_\_

STEP-PARENT'S INFORMATION

Step-parent's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Home or cell phone: \_\_\_\_\_
Address: \_\_\_\_\_
Race/Ethnicity: \_\_\_\_\_ Religious affiliation: \_\_\_\_\_
Highest level of education: \_\_\_\_\_



Marital/relationship status (Check one)

Married: Living with Partner: Single: Separated/Divorced: Widowed: or Other:

Employment status (Check all that apply)

Employed: Retired: Disabled: Student: Homemaker: Unemployed:

If/When employed, what type of work does step-parent do? \_\_\_\_\_

Current employer is: \_\_\_\_\_

Years on current job: \_\_\_\_\_ Business phone: \_\_\_\_\_

Is it OK to contact step-parent at work? Yes No Is it OK to leave a message? Yes No

Special calling instructions? \_\_\_\_\_

REASON FOR SEEKING TREATMENT

Please briefly describe the problems your child is experiencing:

Five horizontal lines for text input.

What has happened to cause you to seek help NOW?

Five horizontal lines for text input.

What do you hope to be able to do or achieve as a result of treatment?

Five horizontal lines for text input.

What do you consider to be other stresses in your child's life?

Five horizontal lines for text input.



HISTORY OF THE PROBLEM

When did your child first start experiencing the problem(s) that brought you to the office today? \_\_\_\_\_

How often does the problem occur? \_\_\_\_\_

How long does it last? \_\_\_\_\_

Does your child have any thoughts of harming himself/herself? Yes No

Has your child ever attempted to harm himself/herself? Yes No If yes, please explain: \_\_\_\_\_

Does your child have any thoughts of harming someone else? Yes No

Has your child ever attempted to harm someone else? Yes No If yes, please explain: \_\_\_\_\_

Has your child received previous intervention/therapy from:

Speech language pathologist: Yes No

If yes, when and for how long? \_\_\_\_\_

Behaviour Specialist: Yes No

If yes, when and for how long? \_\_\_\_\_

Occupational Therapist: Yes No

If yes, when and for how long? \_\_\_\_\_

Has your child ever had other previous therapy/counselling of any kind? Yes No

If yes, when and for how long? \_\_\_\_\_

What concerns were addressed in therapy? \_\_\_\_\_

Was this experience helpful (please explain)? \_\_\_\_\_

Has your child ever been hospitalized for emotional/behavioural problems? Yes No

If yes, when/where was this: \_\_\_\_\_

Has your child been prescribed medications to control emotional/behavioural problems? Yes No

If yes, please list medications, when prescribed, and by whom: \_\_\_\_\_

To your knowledge, has your child experimented with alcohol/drugs? Yes No

Are you concerned that your child might have or be developing a problem with alcohol or drugs?

Yes No If yes, please explain: \_\_\_\_\_

Other



**FAMILY**

Has this child ever experienced any parental separations, divorces or deaths? Yes No  
If yes, when? \_\_\_\_\_ How old was the child at the time? \_\_\_\_\_

Please describe the circumstances: \_\_\_\_\_  
\_\_\_\_\_

If parents are separated or divorced, who has custody of this child? \_\_\_\_\_  
How often does the non-custodial parents see the child? \_\_\_\_\_

Please list the age and sex for each sibling (including deceased and step-siblings):

Age	Sex	Relationship to Child	Living at home?	
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No

Other than any children already indicated above and parents, who else lives in the child’s household?  
\_\_\_\_\_  
\_\_\_\_\_

Has anyone in the child’s family had any treatment for mental/emotional problems? Yes No  
If yes, please briefly explain (who/when): \_\_\_\_\_  
\_\_\_\_\_

Has anyone in the child’s family ever attempted or committed suicide? Yes No  
If yes, please briefly explain (who/when): \_\_\_\_\_  
\_\_\_\_\_

**FAMILY HEALTH**

Describe father’s present health: \_\_\_\_\_

Describe mother’s present health: \_\_\_\_\_

What kinds of stressful events have family members experienced recently?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



What kinds of stressful events has your child experienced recently?

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Have any family member's been diagnosed with any of the following? (Please check if YES):

**If yes, please specify family member's relationship to your child**

<b>Cancer</b>	<b>Mental Retardation</b>
<b>Tourette's Syndrome</b>	<b>Anxiety</b>
<b>Diabetes</b>	<b>Seizures/Epilepsy</b>
<b>Heart Disease</b>	<b>Reading Problems</b>
<b>High Blood Pressure</b>	<b>Speech/Language Problems</b>
<b>Behaviour Disorder (i.e., ODD)</b>	<b>Attention Deficit/Hyperactivity Disorder</b>
<b>Depression</b>	<b>Sleep Difficulties</b>
<b>Autism Spectrum Disorder</b>	<b>Alcohol/Drug Abuse</b>
<b>Schizophrenia</b>	<b>Kidney Disease</b>
<b>Bipolar Disorder</b>	<b>Migraine Headaches</b>
<b>Multiple Sclerosis</b>	<b>Physical Disability</b>
<b>Alzheimer's Disease</b>	<b>Stroke</b>
<b>Other Learning Problem</b>	<b>Tics</b>
<b>Other significant health or emotional problem:</b>	

**CHILD'S MEDICAL CARE AND HISTORY**

Child's Family Physician: \_\_\_\_\_ Clinic and Phone Number: \_\_\_\_\_  
 How often does your child see a doctor? \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
 Pediatrician: \_\_\_\_\_ Naturopathic Doctor: \_\_\_\_\_

Does your child have any history of the following (please check all that apply):

Condition	Age	Treated by whom?	Outcome of treatment
<b>Serious accidents</b>			
<b>Head injury</b>			
<b>Serious illness</b>			
<b>Surgery</b>			
<b>Eye, ear, nose, or throat problems</b>			
<b>Seizures</b>			
<b>High fevers</b>			
<b>Allergies</b>			
<b>Loss of consciousness</b>			
<b>Hospitalizations</b>			
<b>Other: _____</b>			



Please list all current medications your child is taking: \_\_\_\_\_

Supplements: \_\_\_\_\_

Has your child had an eye exam? Yes No Date of last visit: \_\_\_\_\_

Has your child had a hearing test? Yes No Date of last visit: \_\_\_\_\_

**CHILD'S EDUCATION**

Describe any difficulties your child is having in school:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

School (name, city)	Grade	Age	Teacher's Name	School Marks (e.g., A's, B's, C's etc)

**CHILD'S DEVELOPMENT**

Pregnancy and Delivery  
Was your pregnancy planned? Yes No  
Number of previous pregnancies/miscarriages: \_\_\_\_\_  
Describe any complications that occurred during the pregnancy: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



What drugs/medications were used during the pregnancy? \_\_\_\_\_

Mother's age at child's birth? \_\_\_\_\_ Father's age? \_\_\_\_\_

Length of pregnancy: \_\_\_\_\_ weeks Length of labour: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ lbs \_\_\_\_\_ oz

Child's condition at birth: \_\_\_\_\_

If a hospital birth, how long was child's stay in hospital? \_\_\_\_\_

If your child was adopted, please provide adoption history: \_\_\_\_\_

How long was your child breastfed for? \_\_\_\_\_

At what age did your child first sit up? \_\_\_\_\_ First crawl? \_\_\_\_\_ First walk? \_\_\_\_\_ Spoke first word? \_\_\_\_\_

Put two words together? \_\_\_\_\_ Spoke in two to 3 word sentences? \_\_\_\_\_

Any language delays or difficulties? \_\_\_\_\_

At what age was your child fully toilet trained? Daytime: \_\_\_\_\_ Nighttime: \_\_\_\_\_

Did your child experience bedwetting after toilet training? Yes No If yes, until what age: \_\_\_\_\_

Did soiling occur after toilet training? Yes No If yes, until what age: \_\_\_\_\_

Describe your child's sleep pattern? \_\_\_\_\_

What is your child's typical bedtime? \_\_\_\_\_ What time does your child typically wake up? \_\_\_\_\_

Do they have any nighttime waking's? Yes No If yes, how many times typically? \_\_\_\_\_

Any sleep problems?: \_\_\_\_\_

**Please check and comment if the following behaviours apply to your child:**

<b>Anxious</b>	<b>Has frequent temper tantrums</b>
<b>Easily Upset</b>	<b>Has difficulty with changes in routine</b>
<b>Has a low frustration tolerance</b>	<b>Insists on sticking to unusual routines</b>
<b>Engages in repetitive behaviours</b>	<b>Is inflexible in their thinking</b>
<b>Engages in odd behaviours</b>	<b>Has own agenda</b>
<b>Has difficulties with attention</b>	<b>Has difficulty making friends/keeping friends</b>
<b>Is impulsive</b>	<b>Often plays alone</b>
<b>Is often on the go or hyperactive</b>	<b>Is resistant to change</b>
<b>Fidgets or moves around in seat</b>	<b>Seems as if they are in their own world</b>

Comments:

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





As a young child, did your child have problems getting along with others? Yes No

If yes, describe:

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Did your child experience any other problems or delays in the first 5 years? \_\_\_\_\_

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Briefly describe the eating habits of your child (e.g., picky, doesn't eat at the table, night eater, etc.)?

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### CHILD'S INTERESTS AND ACTIVITIES

Please describe your child's strengths and positive characteristics:

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What extracurricular activities (i.e., sports, music, clubs, religious organizations) does your child participate in?

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What hobbies or interests does your child have?

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Any other information you feel is important and was not asked about?

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