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: _____

Dr. Jennie
CHILD & TEEN PSYCHOLOGIST

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:

_____
_____
_____
_____
_____

What has happened to cause you to seek help NOW?

_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

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

_____

_____

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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

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?
_____
_____
_____
_____

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What kinds of stressful events has your child experienced recently?

_____

_____

_____

_____

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

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
☐ **Serious accidents**			
☐ **Head injury**			
☐ **Serious illness**			
☐ **Surgery**			
☐ **Eye, ear, nose, or throat problems**			
☐ **Seizures**			
☐ **High fevers**			
☐ **Allergies**			
☐ **Loss of consciousness**			
☐ **Hospitalizations**			
☐ **Other:_____**			

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:

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

Comments:
_____
_____
_____

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

If yes, describe:

_____
_____

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

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

_____
_____
_____

CHILD'S INTERESTS AND ACTIVITIES

Please describe your child's strengths and positive characteristics:

_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

What hobbies or interests does your child have?

_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____
_____
_____

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