Mark A. Sandberg, Ph.D., ABPP
Licensed Psychologist • Rehabilitation Neuropsychology

CHILD/ADOLESCENT INTAKE QUESTIONNAIRE

This questionnaire was designed to obtain important information about your child so that we may make the best use of our time together. Please be sure to spend time on each question and include as much detail as possible. If there are any specific questions that are unclear to you, please mark them so that we can discuss it further during our initial consultation appointment. Remember that all information that you provide will be kept confidential and will only be used to maximize the efficiency of this evaluation.

Today's Date: _____

PERSONAL INFORMATION

Name of Child: _____ Male ☐ Female☐

Date of Birth: ____/____/____ Birth weight: _____ Handedness: R L Height: _____ Weight: _____ Age:_____

Is your child: biological? ___ adopted? ___ (when:_____) foster child?____

With whom does your child live at the present time? _____

Home address: _____ _____
Phone Number

_____ _____
City State Zip Cell Phone Number

Primary Language: _____ Language used in the home: _____

What supports do you currently have in raising your children? (Check all that apply)

☐ Maternal grandparents ☐Paternal grandparent s ☐Other relatives: _____

☐ Sisters/spouses ☐Brothers/spouses ☐Community group(s)

☐Friends ☐Religious Community ☐Other: _____

Referred by: _____ Telephone: ( ) _____ - _____

Pediatrician: _____ Telephone: ( ) _____ - _____

Other Doctors: _____

Has your child ever been diagnosed with a learning disability? No☐ Yes☐

Has your child ever been diagnosed with Attention Deficit Disorder? No ☐ Yes☐

Other diagnoses/medical conditions: _____

_____

Date of child's last psychological evaluation: _____ By whom? _____

Please describe the results:_____

FAMILY HISTORY

1. Father/Legal Guardian

Name: _____

Address: _____ Home Phone: ( ) _____ - _____

_____ Work Phone: ( ) _____ - _____

Cell Phone: ( ) _____ - _____

Occupation: _____ Highest Education Completed: _____

Does the biological father have any learning difficulties? No ☐ Yes ☐

Describe (language, reading, writing, spelling, math, etc.): _____

Does the biological father have any other disabilities or significant difficulties? No ☐ Yes ☐

Describe (psychological, physical): _____

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2. Mother/Legal Guardian

Name: _____

Address: _____ Home Phone: ( ) _____ - _____

_____ Work Phone: ( ) _____ - _____

Cell Phone: ( ) _____ - _____

Occupation: _____ Highest Education Completed: _____

Does the biological mother have any learning difficulties? No ☐ Yes ☐

Describe (language, reading, writing, spelling, math, etc.): _____

Does the biological mother have any other disabilities or significant difficulties? No ☐ Yes ☐

Describe (psychological, physical): _____

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3. Does your child have any siblings? No ☐ Yes ☐

If yes, please provide the following information about each sibling:

Gender (M/F)	*Age* (years)	*Current Grade*	*Learning Difficulties or Other Disabilities*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Other significant information about your child's family:

Please indicate anybody in the family who has been diagnosed with the following behavioral problems:

Mental Health Disorders ☐No ☐Yes: Person(s):_____ Describe:_____

Mental Retardation ☐No ☐Yes: Person(s):_____Describe:_____

Seizures/Epilepsy ☐No ☐Yes: Person(s):_____ Describe:_____

Serious Chronic Illness ☐No ☐Yes: Person(s):_____ Describe:_____

Substance Abuse ☐No ☐Yes: Person(s):_____ Describe:_____

Trouble With the Law ☐No ☐Yes: Person(s):_____ Describe:_____

Emotional Problems:
(anxiety, depression, bipolar) ☐No ☐Yes: Person(s):_____ Describe:_____

Other neurological disorders:
(brain injury, stroke, dementia) ☐No ☐Yes: Person(s):_____ Describe:_____

Additional Comments: _____

_____

BIRTH HISTORY

Which (1st, 2nd, etc.) was your child of mother's pregnancies? _____

Mother's age at delivery: _____ Father's age at delivery: _____

Pregnancy With your child:

Bleeding? ☐No ☐Yes: Describe:_____

Illness? ☐No ☐Yes: Describe:_____

Was your child born: ☐Early: How Early?_____

☐On Time

☐Late: How Late?_____

Medications taken during pregnancy: ☐No ☐Yes: Describe:_____

Length of labor (hours):_____

Type of labor: False? ☐No ☐Yes Induced? ☐No ☐Yes

Anesthesia? ☐No ☐Yes Natural? ☐No ☐Yes

Type of Delivery (check all that apply):

☐Normal Spontaneous Vaginal ☐Forceps ☐Nuchal Cord (cord around neck)

☐Induced ☐Fetal Distress ☐Twins

☐Caesarean ☐Breech (feet first) ☐

Other:_____

Birthweight:_____ Apgar Score:_____

Color of newborn: ☐Normal? ☐Blue? ☐Jaundiced?

Transfusions? ☐No ☐Yes Incubator Required? ☐No ☐Yes: How long:_____

Breathing Problems? ☐No ☐Yes Oxygen Required? ☐No ☐Yes: How long:_____

Did your doctor note any complications or unusual circumstances with your pregnancy, labor, or delivery?

_____

_____

MEDICAL HISTORY

Has your child experienced difficulties with (check all that apply):

☐Sucking ☐Swallowing ☐Weight Gain ☐Colic ☐Other:_____

☐Feeding ☐Sleeping ☐Breathing ☐Vomiting _____

Has your child ever been hospitalized? ☐No ☐Yes: For How Long: _____

Describe:_____

Has your child ever experienced any of the following? If yes, please describe and indicate any treatment methods used:

☐Measles Age(s):_____ Explain:_____

☐Mumps Age(s):_____ Explain:_____

☐Seizures Age(s):_____ Explain:_____

Was medication received?_____ Specify:_____

When was last seizure?_____ Known cause for seizure(s):_____

☐High fevers Age(s):_____ Explain:_____

☐Meningitis Age(s):_____ Explain:_____

☐Heart Disease Age(s):_____ Explain:_____

☐Whooping Cough Age(s):_____ Explain:_____

☐Chickenpox Age(s):_____ Explain:_____

☐Asthma Age(s):_____ Explain:_____

☐Encephalitis Age(s):_____ Explain:_____

☐Dizzy Spells Age(s):_____ Explain:_____

☐Hearing Defects Age(s):_____ Explain:_____

☐Frequent Colds Age(s):_____ Explain:_____

☐Migraines Age(s):_____ Explain:_____

☐Visual Defects Age(s):_____ Explain:_____

☐Scarlet Fever Age(s):_____ Explain:_____

☐Headaches Age(s):_____ Explain:_____

☐Stomach Pain Age(s):_____ Explain:_____

☐Joint Pain Age(s):_____ Explain:_____

☐Frequent ear infections Age(s):_____ Explain:_____

☐Pneumonia Age(s):_____ Explain:_____

☐Other Serious Illnesses:_____

Has your child received any blows to the head? ☐No ☐Yes: When? _____

Unconscious ☐No ☐Yes: For How Long? _____

How did it happen (describe):_____

Food Allergies:_____

Drug Allergies:_____

Other Allergies:_____

Please describe on the following chart any tests your child has completed:

TEST	*AGE*	*WHERE*	*RESULTS*
Hearing	_____	_____	_____
Vision	_____	_____	_____
EEG	_____	_____	_____
CT Scan	_____	_____	_____
MRI	_____	_____	_____
Allergies	_____	_____	_____
Psychological	_____	_____	_____
Psychoeducational	_____	_____	_____
Other	_____	_____	_____

Describe your child's present physical health:_____

Last physical exam:_____

Is your child currently taking any medication? ☐No ☐Yes

If yes, please fill in the chart below:

Type	*Dosage/Frequency*	*Duration of Treatment*	*Reason(s) Perscribed*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does your child require the use of corrective lenses: ☐No ☐Yes, for reading ☐Yes, for distance

Does your child require a hearing device? ☐No ☐Yes

Has your child experienced any recent changes in appetite? ☐No ☐Yes

Describe (increase/decrease):_____

Average amount of sleep at night:_____ Any recent changes (increase/decrease):_____

DEVELOPMENTAL HISTORY

Please complete the following chart about specific developmental milestones:

Milestone	*Age*
Sat Alone	_____
Walked Alone	_____
Toilet Training	_____
First Word	_____
Spoke 2 or 3 Words Together	_____

Compared to other children, did your child have difficulty:

Speaking? ☐No ☐Yes: Describe:_____

Understanding what others say? ☐No ☐Yes: Describe:_____

Gross motor skills (walking, talking, hopping, riding bike, etc) ☐No ☐Yes: Describe:_____

Fine motor skills (fastening buttons, zippers, drawing, etc) ☐No ☐Yes: Describe:_____

Early school related skills (colors, alphabet, etc) ☐No ☐Yes: Describe:_____

Playing/socializing with other children ☐No ☐Yes: Describe:_____

Building with blocks, play with puzzles, etc ☐No ☐Yes: Describe:_____

Has your child had difficulty in separating? ☐No ☐Yes: Describe:_____

Has your child had any sleeping difficulties? ☐No ☐Yes: Describe:_____

Has your child had any eating difficulties? ☐No ☐Yes: Describe:_____

Which hand does he/she prefer for writing? _____ For sports? _____

When did your child show a clear hand preference?_____

Does your child play with older, younger, or same age children?_____

If your child has any hobbies, please describe them:_____

_____

If your child has any family responsibilities/chores, please describe them:_____

_____

EDUCATIONAL HISTORY

List schools attended, including any day care centers and preschools. Please begin with the most recent.

School/Agency Name	*City/State*	*Years There*	*Age/Grade*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Did your child skip any grades in school? ☐No ☐Yes: Which?_____

Did your child repeat any grades in school? ☐No ☐Yes: Which?_____

Why?_____

Did your child have a pre-kindergarten screening? ☐No ☐Yes: Did he/she pass?_____

Elementary Schooling:

What subjects, if any, were difficult for your child to learn in elementary school (reading, math, writing cursive, succeeding in physical education, making and keeping friends, conduct, completing seatwork?):_____

_____

How would your child's elementary school teachers describe him/her?

_____

_____

_____

Secondary Schooling:

What areas, if any, were difficult for your child in middle and high school (writing compositions, reading long assignments, social skills, oral presentations, foreign language, algebra, geometry, study skills)? _____

_____

_____

How would your child's middle and high school teachers describe him/her? __

_____

_____

High school GPA _____ Average English Grades _____ Average Math Grades _____

List any honors, awards, or other kinds of special recognition your child has received: _____

_____

_____

Best SAT score (if taken): Verbal: _____ Math: _____

Was test: ☐Timed ☐Untimed ☐Extended Time

Prep course? ☐No ☐Yes: Describe:_____

Best ACT score (if taken): _____

Was test: ☐Timed ☐Untimed ☐Extended Time

Prep course? ☐No ☐Yes: Describe:_____

At what age did concerns become noticeable?_____

_____

Describe any behavior or conduct problems during the elementary and secondary school years: _____

_____

_____

Has your child ever experienced the following (check all that apply):

☐Special Education Classes Grade/Age_____ Describe:_____

☐Inclusion Classes Grade/Age_____ Describe:_____

☐Tutoring Grade/Age_____ Describe:_____

☐Summer School Grade/Age_____ Describe:_____

☐Enrichment/Gifted Programs Grade/Age_____ Describe:_____

☐Language Immersion Grade/Age_____ Describe:_____

☐Resource Room Grade/Age_____ Describe:_____

☐Speech/Language Services Grade/Age_____ Describe:_____

☐Occupational Therapy Grade/Age_____ Describe:_____

☐Other (describe) Grade/Age_____ Describe:_____

Does your child currently have an Individualized Educational Plan? ☐No ☐Yes 504 plan? ☐No ☐Yes

Does your child have resource room help now? ☐No ☐Yes

If so, for which academic skills? _____

Has your child had frequent change of school? ☐No ☐Yes

If yes, why: _____

Does your child have any trouble doing his/her homework? ☐No ☐Yes

If yes, describe: _____

How are problems with homework usually handled? _____

_____

_____

SOCIAL/EMOTIONAL AND BEHAVIORAL FUNCTIONING

How would other children describe your child: _____

_____

Does your child typically exhibit any problems in friendships (teasing, aggressiveness, rejection, etc.)? _____

_____

_____

Does your child feel accepted by peers? _____ Parents? _____ Siblings? _____

What makes your child feel guilty? Does he/she often feel that way? _____

_____

_____

How does your child show affection? _____

Is it hard for your child to trust people? _____ Does he/she feel comfortable around others? _____

_____

How often does your child feel really angry? What makes him/her feel this way and how does he/she cope with it?

_____

_____

Is your child a worrier? _____ What types of things does he/she worry about? _____

_____

Does your child display any nervous habits (such as nail biting, thumb sucking, hair pulling, etc)? _____

_____

Would you describe your child as obedient? _____

How is he/she punished? _____

For what and how often? _____

Is it effective? _____

Does your child exhibit any other unusual or problematic behaviors not mentioned above? _____

_____

_____

Have there been any recent changes or stressors in your child's life, or in the family? _____ Describe: _____

_____

On average, how much time (per week) does your child spend with:

Father _____ hrs Typical activities together: _____

Mother _____ hrs Typical activities together: _____

Does your child spend time with any other adults on a regular basis? _____

_____

ADDITIONAL COMMENTS

What is *your* purpose in seeking this evaluation? _____

_____

_____

Describe what you see as your child's personal strengths/strong points: _____

_____

_____

Is there any other information about your child and his/her family circumstances, development, or medical condition that you would like to share? _____

_____

_____

_____

_____

_____

This form was completed by:

_____ _____

Signature Print Name

_____ _____

Date Completed Relationship to Child