Patient #___________

Psychological Health-Roanoke
Child Intake

Child's Name _________________________________ Date of Birth ____________________________ Age _____

Address ____ Sex ____ Race ______

Street

____

City State Zip Code County

Parent (s) or Guardian (s) ____

Home Telephone # _________________________________ Message # __________________________________

Work- Mother ______________________________________ Father________________ ____________________

Who referred you here? Name, Address & Relationship to Child

____

Has the child been seen at Lewis-Gale Psychological Health or Psychological Health-Roanoke?

______ If yes, when? ____

Signature of person completing this form- ____

Relationship to child ______________________________________ Date __________________________________

I. FAMILY HISTORY

Father's Name ____ Date of Birth _________________________

First Middle Last

Occupation ____ Employer _______________________

Highest Grade Completed ______________________________ Other vocational training ______________________

Mother's Name ____ Date of Birth _____________________________

First Middle Last

Occupation ____ Employer __________________________

Highest Grade Completed _____________ Other vocational training ____

Marital status of parents ______________________ Marriage date ____

Date divorced, if applicable _________________________ Death of parent, if applicable _______________________

How long has the family lived at the current address? ____

Where else has the family lived during the child's life?

____

____

List all persons living in the home:

Name Age Relationship to child

____

____

____

____

II. PARENTAL CONCERNS

What do you think is your child's main problem?

____

____

________________________What have you been told by doctors, teachers and/or others about you child's problem?

____

____

____

What do you expect or hope to have happen as a result of an evaluation with this clinic?

____

____

What have you done to resolve the current problem?

____

____

III. PREGNANCY HISTORY

Did the mother:	Yes	No	What Month	Complications/Medications
Drink alcoholic beverages (Indicate how much)	___	___	__________	____________________
Smoke (Indicate how much)	___	___	__________	____________________
Take medications or drugs (Other than vitamins/iron)	___	___	__________	____________________
Have other illnesses or medical problems	___	___	__________	____________________

IV. BIRTH INFORMATION

Length of pregnancy ____________ Length of labor ___________________ Was labor induced? __________________

Birth was: Normal _____________ Cesarean ____________________ Breech ____________ Twins or more _______

Were forceps used? ___________________________ Did mother have complications? _________________________

If yes, please specify:

Birth weight ______________________________ How long did baby stay in the hospital after birth? _______________

Did baby need medical assistance in starting to breathe? _______ ____

Other complications? ____ If yes, please specify:

____

V. CHILD'S GROWTH AND DEVELOPMENT

1. Motor Skills: (Write "not yet" where appropriate)

At what age did your child:

Smile _________ Roll over _________ Sit without support _________ Crawl _________

Pull to standing ________ Walk alone _________ Pedal a tricycle __________

What concerns, if any, do you have about your child's motor development?

____

2. Language and Hearing: (Write "not yet" where appropriate)

Do you feel your child hears: Well _______ Poorly _______ Not at all ________

Inconsistently _______ Uncertain _______

Does your child communicate mostly by: Gestures _______ Words _______ Crying _______

Phrases _______ Sentences _______

Has your child ever had PE tubes? ______ At what ages? ___________

What age did your child: Make single sounds _______ Use words _______

Combine words to make sentences _______

Did your child begin to use words and then stop? ____ At what age? ____

What concerns do you have about your child's speech, language or hearing?

____

____

3. Feeding: (Write "not yet" where appropriate)

Was your child bottle fed? ___ Breast fed? _____

For his/her age, is your child: Average ____ Underweight ___ Overweight _____

Has you child had any problems with:

Feeding ___ Chewing ___ Teeth ___ Swallowing ___

What eating problems or unusual food habits does your child have?

____

____

4. Personal/Social: (Write “not yet” where applicable)

At what age did your child: give up the bottle ______ feed him/herself ______

Drink from a cup ______ dress him/herself ______

At what age was he/she: bladder trained ______ bowel trained _______

VI. MEDICAL HISTORY

Has your child ever been seriously ill? ___ If yes, with what____

____

Has your child ever been hospitalized? ___ If yes, why? ____

____

When:________________________ Where: ____

(Name and address of hospital)

List all medications your child currently takes, amounts and reason for taking:

Medicine Amount Reason

____

____

____

Check any of the following which pertain to your child, indicating age and complications.

	Age	Complications		Age	Complications
___Meningitis	___	____________	___Seizure	___	___________
___Fainting spells	___	____________	___Headaches	___	___________
___Visual problems	___	____________	___Ear Infections	___	____________
___ Developmental Delay	___	____________	___ Other (Specify)	___	____________

VII. FAMILY HISTORY

Complete the following table for all of the mother's pregnancies in chronological order, including any miscarriages or stillbirths. (Please write on back if additional space is needed).

Name	Date of Birth	Birth Weight	Length of Pregnancy	Length of Labor	Problems at Birth	Any physical, emotional, behavioral, or educational problems?

Please note below if any of the child's relatives have had any of the following conditions (For example, brother, aunt, cousin, grandparent).

	Relationship To Child		Relationship To Child
Convulsions	___________	Cerebral Palsy	___________
Hearing Loss	___________	Mental Illness	__________
Mental Retardations	___________	Speech Problems	___________
School Difficulties	___________	Muscular Weakness	___________
Visual Impairment	___________	Deformities	___________
Alcoholism	___________	Emotional Problems	___________
Overactivity, attention problems	___________	Other	___________

Describe any of the above ____

____

What stressors have impacted your family recently? (i.e. deaths, marital conflicts, etc.)

____

____

VIII. BEHAVIOR

What problems are you experiencing with your child's behavior?

____

____

Who else (i.e. school, sitter) is having problems with your child's behavior?______________

____

____

IX. SCHOOL HISTORY

If your child has been to school, please complete the following, beginning with nursery/day care and ending with current placement. (If more room is needed, please use the other side of this page).

School	Address	Grade or Class Placement	Dates of Attendance

Have you requested testing from the school? ___Yes ___ No

Is any testing scheduled? ___ Yes ___ No If yes, when? ________________

X. PLEASE LIST THE NAMES AND ADDRESSES OF OTHER PROFESSIONALS WHO HAVE WORKED WITH YOU AND YOUR FAMILY.

	Name	Complete Address
Pediatrician		
Mental Health Professional		
Specialist (specify)		

FOR CLINICIAN USE ONLY:

DX: ____
____
____

GOALS:
1. ____
2. ____
3. ____
4. ____