LINKED Social Skills Classes

Intake Form

Child's name: _____ Sex: _____ male _____ female

Date of birth: _____/_____/_____ Current age: _____ Grade: _____

Referred by: _____ self _____ agency _____ professional _____ friend

Name: _____ phone: _____

Address: _____

Please briefly describe the issues or concerns for which you are presently seeking services for your child: _____

_____

_____

Parent marital status: _____ married _____ divorced _____ separated _____ single

Primary contact: _____ mother _____ father _____ other/guardian (describe) _____

Mother's name: _____ age: _____ education: _____

Occupation: _____ Where employed: _____

phone #s: home: _____ work: _____ cell: _____

Address: _____

Email: _____

Father's name: _____ age: _____ education: _____

Occupation: _____ Where employed: _____

phone #s: home: _____ work: _____ cell: _____

Address(if different): _____

Email: _____

FAMILY INFORMATION

of other persons living in the child's home at the **current** time: _____

Name	Relationship	DOB, age & gender	Occupation/grade

Are other members of your immediate family currently not living with you? _____ yes_____ no

Name	Relationship	DOB, age & gender	Occupation/grade

Are there any significant family stressors that may be impacting your child? _____ yes _____ no

If so, describe _____

BACKGROUND INFORMATION

Pregnancy: Prenatal care: _____yes _____ no # of pregnancies: _____

Accidents or illnesses during pregnancy:_____

alcohol used: _____yes _____ no smoked during: _____yes _____ no
x-rays during: _____yes _____ no medications used: _____yes _____ no
full-term: _____ yes _____ no # of wks _____

mother's age at delivery: _____ father's age at delivery: _____

City, state of birth: _____

Delivery: _____ vaginal _____ caesarian section.

Complications: breech? _____yes _____ no forceps: _____yes _____ no
induced? _____yes _____ no fetal distress? ___ yes ____no
cord around neck: ___yes ____ no other: _____

Newborn: Birth weight: _____ lbs _____oz.

APGAR scores: 1 min: _____ 5 min: _____

Length of stay in the hospital: _____

Procedures performed in hospital: _____

_____

Did any of the following occur? jaundice: _____ breathing difficulties: ___
congenital defects: _____feeding difficulties: _____
infection_____ turned blue: _____

Infancy: illnesses: _____

accidents: _____

injuries: _____

hospitalizations: _____

The age developmental milestones were achieved:

rolled over: _____ sat independently:_____ crawled: _____

walked independently: _____ laughed: _____ mouthing non-edibles: _____

said 1st word: _____ put 2 words together: _____ said simple sentences: _____

feed self: _____ toilet trained: _____ regression in skills? _____

tied shoelaces: _____ rode a bike: _____

Did your child have a delay in the development of spoken language? ____yes _____ no

If your child is verbal, please describe their current ability to initiate or sustain a conversation:

_____

Please describe any concerns you may have about your child's development: _____

_____

HISTORY OF TREATMENT

Has your child received the following therapy or treatment?

occupational therapy: _____ # of times per week from _____ to _____

physical therapy: _____ # of times per week from _____ to _____

speech therapy: _____ # of times per week from _____ to _____

discrete trials: _____ # of times per week from _____ to _____

psychotherapy : from: _____to: _____

psychiatric treatment: from: _____to: _____

drug/alcohol treatment: from: _____to: _____

Have you previously sought or received psychological or psychiatric help, counseling, or assessment for your child? _____ yes _____ no if yes, describe briefly: _____

_____

If so, by whom?

Name:_____

Address: _____

Phone #: _____ fax #: _____

Name:_____

Address:_____

Phone #: _____ fax #: _____

Has your child received a diagnosis in the past? _____ yes _____ no. if yes, when?: _____

For what? _____

& by whom? _____

FAMILY HISTORY

Does anyone in the family have the following (if so, please briefly describe):

attentional problems: _____

mental health problems: _____

speech and language delays: _____

hyperactivity: _____

developmental delays: _____

learning problems: _____

allergies: _____

medical illnesses: _____

other: _____

MEDICAL HISTORY

Pediatrician name: _____ phone #: _____

Date of last physical exam: _____/ _____/ _____

Hearing: date of last assessment: ____/____/____ passed: _____ failed: ____

hearing sensitivity: _____ yes _____ no

chronic ear infections: _____ yes _____ no total #: _____

number of tubes: _____ right _____ left

tonsillectomy: _____ yes _____no date: _____/ _____/ _____

adenoidectomy: _____ yes _____ no date: _____/ _____/ _____

Vision: date of last assessment: _____/_____/_____

corrective lenses: _____ yes _____ no other problems: _____

surgeries: _____

Is your child currently receiving medical care? _____ yes _____ no If yes, describe briefly:

_____

Current medications (please include herbal supplements and home remedies):

Name of medication	Date of prescription	Purpose of medication

Has your child ever experienced any of the following?

allergies: _____ asthma: _____ blackouts: _____
breathing problems: _____ cerebral palsy: _____ change in appetite: _____
change in sleep: _____ chicken pox: _____ congenital problems: _____
diabetes: _____ dizziness: _____ ear aches/infections: _____
eczema: _____ encephalitis: _____ fainting spells: _____
fatigue: _____ headaches: _____ heart defects: _____
high fevers: _____ hives: _____ lead poisoning: _____
measles or mumps: _____ memory loss: _____ meningitis: _____
multiple sclerosis: _____ muscular dystrophy: _____ nose bleeds: _____
paralysis: _____ pneumonia: _____ reflux: _____
reactions to immunizations: _____ seizures/convulsions: _____ severe head injury: _____
severe nausea: _____ severe vomiting: _____

Medical tests conducted/results (MRI, EEG, blood tests, other): _____

_____

Specialists seen/results: (neurologist, orthopedist, ophthalmologist, etc.): _____

_____

_____

SCHOOL HISTORY

Did your child attend preschool: _____ yes _____ no If so, age/duration:_____

School name:_____ & # of days per week your child attended: _____

Please describe your child's school history below:

Grade(s)	Name of school	Public/private/ home/other

Is your child in: _____ regular education _____ the gifted program _____ special education

Please describe any current school problems? _____

_____

Has your child ever been evaluated for special education: _____ yes _____ no. If yes, please describe:

_____

Has your child been retained? _____ yes _____ no. if yes, please describe: _____

What kinds of grades does your child get in school? _____

What is your child's easiest classes? _____

Hardest classes? _____

How does the teacher describe your child's academic abilities? _____

_____

Does your child sometimes miss school because of:

Fear or anxiety? _____ yes _____ no. how often? _____

Minor illnesses such as stomachaches or headaches? _____ yes _____ no. how often? _____

Has your child ever left a previous school? _____ yes _____ no. if so, please describe the reason: __

_____

Please check the descriptions which relate to your child:

Feelings about school work: _____ anxious _____ passive _____ enthusiastic _____ fearful

_____ eager _____ no expression _____ bored _____rebellious

Approach to school work: _____ organized _____industrious _____ responsible

_____interested

_____ self-directed _____ no initiative _____ refuses _____does only what is expected

_____sloppy _____ disorganized _____ cooperative _____ doesn't complete assignments

Performance in school: _____ satisfactory _____underachiever _____ overachiever

GETTING TO KNOW YOUR CHILD

Has anything ever happened to your child that upset them badly? _____ yes _____ no. if so, what Happened & when? _____

What was your child's reaction? _____

_____

Has your child ever:

_____ been badly hurt or very sick
_____ been in a fire
_____ been inappropriately touched or molested
_____ other _____
_____ seen someone die or be injured
_____ been physically attacked
_____ been through a hurricane, flood, or other disaster

Does your child have a history of:

frequent illness	_____ yes _____ no	vomiting	_____ yes _____ no
weight loss	_____ yes _____ no	not eating	_____ yes _____ no
overeating	_____ yes _____ no	excessive exercise	_____ yes _____ no
repeating things	_____ yes _____ no	excessive studying	_____ yes _____ no
perfectionism	_____ yes _____ no	trouble learning	_____ yes _____ no
reading problems	_____ yes _____ no	math problems	_____ yes _____ no
language delays	_____ yes _____ no	rocking	_____ yes _____ no
tics	_____ yes _____ no	unusual mannerisms	_____ yes _____ no
head banging	_____ yes _____ no	hand flapping	_____ yes _____ no
bedwetting	_____ yes _____ no	soiling pants	_____ yes _____ no

seeing images	_____ yes _____ no	hearing voices	_____ yes _____ no
hurting self	_____ yes _____ no	hurting others	_____ yes _____ no
trouble with the law	_____ yes _____ no	skipping school	_____ yes _____ no
drug use	_____ yes _____ no	alcohol use	_____ yes _____ no
stealing	_____ yes _____ no	other: _____	

Compared to other children your child's age how would you describe your child's:

	low	average	high	very high
motor skills:	_____	_____	_____	_____
need for attention:	_____	_____	_____	_____
ability to learn:	_____	_____	_____	_____
ability to stay on task:	_____	_____	_____	_____
activity level:	_____	_____	_____	_____
distractibility:	_____	_____	_____	_____
concentration:	_____	_____	_____	_____
aggressiveness:	_____	_____	_____	_____
lying:	_____	_____	_____	_____

Does your **child complain** of the following somatic concerns:

frequent headaches:	_____ yes _____ no	frequent stomachaches:	_____ yes _____ no
nightmares:	_____ yes _____ no	fears:	_____ yes _____ no
eating problems:	_____ yes _____ no	sleeping problems:	_____ yes _____ no

Does your child have difficulty falling asleep? _____ yes _____ no. if yes, please describe: _____

Does your child have nightmares or bad dreams? _____ yes _____ no

Does your child seem to worry more than other kids? _____ yes _____ no. if so, what about?

_____ school (grades or homework, for example) _____ health
_____ performance (being good enough) _____ things in the past
_____ family (e.g., divorce or money) _____ being on time
_____ things going on in the world (e.g., war or crime) _____ things being neat/clean/orderly

Does your child worry excessively when he/she is away from you? _____ yes _____ no

If yes, how do they express their worry? _____

Does worrying prevent your child from concentrating on things? _____ yes _____ no

Does your child have repeated thoughts or images that they can't stop? _____ yes _____ no. if so, please describe: _____

Does your child do the same thing over and over in a special order or manner? _____ yes _____ no if yes, please describe: _____

Do any of the following make your child especially nervous or anxious (check all that apply)?

_____ speaking out loud in school _____ asking the teacher a question
_____ taking a test _____ working or playing in a group
_____ gym class _____ walking in hallways
_____ using public bathrooms _____ eating in public

_____ talking on the phone _____ musical or athletic performance
_____ getting together with friends _____ dating
_____ saying no if they don't want to do something _____ telling someone to stop

Does he or she have trouble finishing things? _____ yes _____ no
Does your child seem to lose things often? _____ yes _____ no
Does your child have trouble sitting still? _____ yes _____ no
Is your child often fidgety? _____ yes _____ no
Is your child easily distracted? _____ yes _____ no
Do you find yourself having to discipline your child for acts like running indoors, climbing on furniture, or yelling? _____ yes _____ no
Does your child have trouble waiting for his/her turn when playing in a group? _____ yes _____ no

Does your child often feel sad or blue? _____ yes _____ no
Is your child often tired or listless? _____ yes _____ no
Is your child often irritable? _____ yes _____ no
Has your child ever talked about suicide or death? _____ yes _____ no
Does your child seem to feel: _____ worthless _____ guilty _____ hopeless about the future

Does your child has as many friends as most other children? _____ yes _____ no
How easily does your child make friends with:
older children: _____ younger children: _____
same age children: _____ adults: _____
Would your child rather play alone or with others? _____
Does your child have a best friend? _____ yes _____ no
What kind(s) of activities does your child like to do with other children?_____
_____

Does your child actively participate (or show interest in) social play or games such as hide-and-seek or ring-around-the-rosie? _____ yes _____ no
Does your child engage in imaginative games? _____ yes _____ no. if yes, please describe:
_____
Does your child have trouble making friends? _____ yes _____ no
Does your child prefer to be alone? _____ yes _____ no
What kind(s) of activities does your child like to do alone?_____
_____

How long can your child entertain him/herself? _____

What toys or objects does your child prefer? _____

How long does your child play with a toy? _____

What are your child's hobbies/interests?_____

Does your child participate in any extracurricular activities? _____ yes _____ no. if so, which ones:
_____

Does your child get into fights at school? _____ yes _____ no
Do you think your child gets bullied? _____ yes _____ no
Do you think your child might threaten or intimidate other children? _____ yes _____ no

Has your child ever used a weapon such as a bat, knife, or gun? _____ yes _____ no
Has your child ever hurt a pet or other animals? _____ yes _____ no
Has your child ever set anything on fire which caused damage? _____ yes _____ no
Has your child ever been in trouble for destroying property or fighting? _____ yes _____ no
Do you think your child uses alcohol or drugs? _____ yes _____ no
Has your child ever run away from home? _____ yes _____ no

How do you typically manage your child's behaviors?_____

What type of discipline do you use? _____

Please describe as your child's strengths: _____

_____

How, if in any way, would you like to interact differently with your child? _____

_____

What time of day does your child function best? _____

What do you hope to gain from this evaluation or treatment? _____

_____

Thank you for taking the time to complete this comprehensive form. by completing the form, you have aided my office in the best available treatment to you and your family.

Sincerely,

Dr. Allison Randel.