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Child Intake Information Form

Please bring this completed questionnaire with you to your first appointment.

Child's Name: _____ DOB: _____ Age: _____
Last, First

Home Address: _____
Street City State Zip Code

Home Phone: _____

Home E-mail: _____

Child's School: _____
Name Address Grade

Biological Parents:

Parent's Name: _____ Relation: _____

Business Name: _____ Business Phone: _____

Can we call you at work if necessary? Yes _____ No _____

Parent's Name: _____ Relation: _____

Business Name: _____ Business Phone: _____

Can we call you at work if necessary? Yes _____ No _____

Permission to Provide Professional Services to My Child: We generally need to have both biological parent's permission for your child to receive professional services from our office, unless we have copies of a legal document indicating otherwise. If you are living together, we will usually give you one Child Intake Information Form to complete - you should both provide permission for your child to receive professional services from our office through your signatures below. If you are separated, we will give you two Child Intake Information Forms to complete, and you should both provide permission for your child to receive professional services from our office through your signature on the Child Intake Information Form you receive. Either or both parent are able to obtain copies of our records for their child, unless we have copies of a legal document indicating otherwise. Through my signature below, I give Dr. Root and his Associates permission to provide professional services to my child.

Parent's Signature

Parent's Signature

Date

Date

Other Adult(s) Involved With Child (Use Reverse Side of Page as Necessary):

Name: _____ Relation: _____

Home Phone: _____ Business Phone: _____

Person we can call if we cannot reach you in an emergency:

Name: _____ Relation: _____

Home Phone: _____ Business Phone: _____

Who Referred You To Our Office? _____

Problems Seeking Consultation For:

- 1. _____
- 2. _____
- 3. _____

Current Stressors/Triggers That "Cause" These Problems:

- 1. _____
- 2. _____
- 3. _____

Pregnancy:

- Complications: _____
- Alcohol Consumption During Pregnancy: _____ Amount: _____
- Smoking Consumption During Pregnancy: _____ Amount: _____ X-Ray Studies During Pregnancy: _____
- Medications Taken During Pregnancy: _____
- Length of mother's pregnancy (check one): 37+ weeks _____; 32 to 37 weeks _____; less than 32 weeks _____.

Delivery:

- Complications: _____
- Infant Injured During Delivery? (If Yes, Specify Type): _____

Post-Delivery Period (While in Hospital):

- Birth Weight: _____ Total # of days baby was in the hospital after delivery: _____
- Respiration: Immediate _____ Delayed (If So, How Long) _____
- Cry: Immediate _____ Delayed (If So, How Long) _____
- Cyanosis (Turned Blue): _____ Incubator Care: _____ Number of Days: _____
- Suck: Strong: _____ Weak: _____ Infection(s) (Specify): _____
- Birth Defects (Specify): _____

Infancy/Toddler Period: Were any of the following present to a significant degree during the first few years of life? If so, please describe.

- Did not enjoy cuddling: _____
- Was not calmed by being held and/or stroked: _____
- Excessively Restlessness: _____
- Diminished sleep because of restlessness & easy arousal: _____
- Frequent head banging: _____
- Constantly into everything: _____
- Excessive number of accidents compared to other children: _____

When Did Your Child Reach the Following Developmental Milestones?

Developmental Milestone	Age	Early	Normal Time	Late
• Smiled:	_____	_____	_____	_____
• Sat without support:	_____	_____	_____	_____
• Crawled:	_____	_____	_____	_____
• Stood without support:	_____	_____	_____	_____
• Walked without assistance:	_____	_____	_____	_____
• Spoke first words besides "Ma-Ma" and "Da-Da":	_____	_____	_____	_____
• Said phrases:	_____	_____	_____	_____
• Said sentences:	_____	_____	_____	_____
• Bowel trained (Day):	_____	_____	_____	_____
• Bowel trained (Night):	_____	_____	_____	_____
• Bladder trained (Day):	_____	_____	_____	_____
• Bladder trained (Night):	_____	_____	_____	_____
• Rode tricycle:	_____	_____	_____	_____
• Rode bike w/out training wheels:	_____	_____	_____	_____
• Buttoned clothing:	_____	_____	_____	_____
• Tied shoelaces:	_____	_____	_____	_____
• Named colors:	_____	_____	_____	_____
• Said alphabet in order:	_____	_____	_____	_____
• Began to read:	_____	_____	_____	_____

Rate your Child's Coordination in the Following Areas:

	Good	Average	Poor
• Walking:	_____	_____	_____
• Running:	_____	_____	_____
• Throwing:	_____	_____	_____
• Catching:	_____	_____	_____
• Shoelace Tying:	_____	_____	_____
• Buttoning:	_____	_____	_____
• Writing:	_____	_____	_____
• Athletic Abilities:	_____	_____	_____

Comprehension and Understanding:

Do you consider your child to understand directions and situations as well as other children his or her own age? _____ If not, why not? _____

Intellectual Ability:

How would you rate your child's intelligence compared to other children? (Circle One)
Below Average Average Above Average

School:

* Rate your child's school experience related to Academic Learning:

Good Average Poor

- Nursery School: _____
- Kindergarten: _____
- Current Grade: _____

* To the best of your knowledge, at what *grade level* is your child currently functioning?

Reading: _____ Spelling: _____ Arithmetic: _____

* Has your child ever had to *repeat a grade*? If so, when: _____

* Present class placement: Regular Class: _____ Special Class (Specify Type): _____

* Kinds of special therapy or remedial work your child is currently receiving: _____

* Describe briefly any academic school problems: _____

* Rate your child's school experience related to behavior:

Good Average Poor

- Nursery School: _____
- Kindergarten: _____
- Current Grade: _____

* Please circle any of the following classroom problems your child's teacher describes as significant:

- Doesn't sit still in his/her seat
- Frequently gets up and walks around the classroom
- Shouts out – doesn't wait to be called upon
- Won't wait his or her turn
- Does not cooperate well in group activities
- Typically does better in an one-to-one relationship
- Doesn't respect the rights of others
- Doesn't pay attention during storytelling

Describe briefly any other classroom behavioral problems: _____

Peer Relationships:

- Does your child seek friendships with peers? _____ Do peers seek friendship with your child? _____
- Does your child play primarily with children his or her own age? (Circle One)
Or younger children? _____ Or older children? _____
- Describe briefly any problems your child may have with peers: _____

Interests and Accomplishments:

- What are you child's main hobbies, interests, and enjoyments? _____
- What are your child's areas of greatest accomplishments? _____
- What does your child like doing least? _____

Medical History: If your child's medical history includes any of the following, please note the age when the incident or illness occurred and other pertinent information.

- Childhood diseases (describe any complications): _____
- Operations: _____
- Hospitalizations for illness(es) other than operations: _____
- Head Injuries: _____
 With unconsciousness _____ Without unconsciousness _____
- Convulsions: _____ With fever _____ Without fever _____
- Coma: _____
- Meningitis or Encephalitis: _____
- Immunization Reactions: _____
- Persistent High Fevers: _____ Highest Temperature Recorded: _____
- Eye Problems: _____
- Ear Problems: _____
- Poisoning: _____

Present Medical Status:

- Present height: _____ Present weight: _____
 - Present illness(es) for which child is being treated: _____
 - Medications child is taking on an ongoing basis (*include drug name and dosage*): _____
- _____
- _____

Trauma History:

Has the child been exposed to a traumatic event (s), including physical, sexual or emotional/verbal abuse, which involved actual or threatened serious psychological or physical injury to him/her or others close to the client?

Yes _____ No _____ If yes, specify the dates, frequency and duration of the trauma:

If yes, was the child's response a disorganized or agitated one? Yes _____ No: _____

Family History of the Biological Mother of the Child:

- Current Age: _____
 - Age at the time of pregnancy with patient: _____
 - Number of Previous Pregnancies: _____
 - Number of Spontaneous Abortions (Miscarriages): _____
 - Number of Induced Abortions: _____
 - School: Highest Grade Completed: _____ Grades Repeated: _____
 - Psychological Problems (Specify): _____
 - Learning Problems (Specify): _____
 - Behavioral Problems (Specify): _____
 - Medical Problems (Specify): _____
 - Have any of your blood relatives (not including patient and siblings) ever had problems similar to those your child has? If so, describe: _____
- _____
- _____

Family History of the Biological Father of the Child:

- Current Age: _____
- Sterility Problems (Specify): _____
- School: Highest Grade Completed: _____ Grades Repeated: _____
- Psychological Problems (Specify): _____
- Learning Problems (Specify): _____
- Behavioral Problems (Specify): _____
- Medical Problems (Specify): _____
- Have any of your blood relatives (not including patient and siblings) ever had problems similar to those your child has? If so, describe: _____

Siblings of the Child:

	Name	Age	Psychoeducational or Medical Problems
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Other Professionals Consulted With Regarding Child's Problems:

	Name	Phone	Address
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Please use the remainder of this page to write any additional comments you wish to make regarding your child's difficulties: _____

**Thank you for answering these questions.
Your answers are most valuable in understanding your child.
We look forward to seeing you.**