WAYNE STATE UNIVERSITY
Psychology Clinic

CHILD INTAKE INFORMATION

This form is being filled out by _____

Who referred to our clinic? _____

What is the reason for referral? _____

_____

When were the problems first noticed? _____

Today's date _____

Family information

Patient

Child's name _____

Likes to be called _____ Preferred gender pronoun (e.g., he, they) _____

Birth date _____ Age _____ Ethnicity _____

Address _____

City _____ State _____ Zip code _____

Parent/legal guardian 1

Biological? Yes ☐ No ☐

If no, what is your relationship to the child? _____

Name _____

Age _____ Ethnicity _____

Address _____

WAYNE STATE UNIVERSITY
Psychology Clinic

CHILD INTAKE INFORMATION

City _____ State _____ Zip code _____

Home phone _____-_____-_____ Work phone _____-_____-_____

Martial status: Single ☐ Married to child's other parent ☐ Separated ☐ Divorced ☐
Remarried ☐ Living with partner/someone else ☐ Never married ☐

Education *(select the highest level completed)*

Grade school: ☐ 1 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐

High school: ☐ 9 ☐ 10 ☐ 11 ☐ 12

College: Partial ☐ Four-year degree ☐

Graduate: Partial ☐ Degree ☐

Employment

Job title _____ Type of work _____

Employer _____

If unemployed, list most recent employment _____

Date last employed _____

Parent/legal guardian 2

Biological? Yes ☐ No ☐

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Name _____

Age _____ Ethnicity _____

Address _____

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CHILD INTAKE INFORMATION

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Continue to next page.

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CHILD INTAKE INFORMATION

If child lives with a stepparent or another guardian *(e.g., grandparent, aunt, foster mother)*, please provide the following information below.

Stepparent or guardian

Name _____

Relationship _____

Education *(select the highest level completed)*

Grade school: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

High school: ☐ 9 ☐ 10 ☐ 11 ☐ 12

College: Partial ☐ Four-year degree ☐

Graduate: Partial ☐ Degree ☐

Employment

Job title _____ Type of work _____

Employer _____

If unemployed, list most recent employment _____

Date last employed _____

Who lives with child? Give name, age, preferred gender label and relationship to child (e.g., mother, father, brother) of all household members.

) Name _____ Age _____

Relationship to child _____ Preferred gender pronoun _____

) Name _____ Age _____

WAYNE STATE UNIVERSITY
Psychology Clinic

CHILD INTAKE INFORMATION

Relationship to child _____ Preferred gender pronoun _____

⟩ Name _____ Age _____

Relationship to child _____ Preferred gender pronoun _____

⟩ Name _____ Age _____

Relationship to child _____ Preferred gender pronoun _____

Please list the name, age, and sex of any brothers or sisters who do not live with child.

⟩ Name _____ Age _____

Preferred gender pronoun _____

⟩ Name _____ Age _____

Preferred gender pronoun _____

⟩ Name _____ Age _____

Preferred gender pronoun _____

Who is the child's regular physician? _____

Address _____

Phone _____-_____-_____

If s/he does not have a regular physician, where is the child taken when a doctor is needed? _____

_____

CHILD INTAKE INFORMATION

What grade is the child in? _____ What school? _____

Has the child repeated a grade? Yes ☐ No ☐ If so, which grade? _____

Does the child receive special education services? Yes ☐ No ☐

If so, which type? Educable mentally impaired (EMI) ☐ Emotionally impaired (EI) ☐

Learning disabilities (LD) ☐ Physical or health impaired ☐ Speech therapy ☐

Occupational ☐ Other _____

Does child receive tutoring outside of school? Yes ☐ No ☐

If yes, where and when? _____

Has the child been tested by the schools for learning problems? Yes ☐ No ☐

Medical and development history for identified child client

Besides vitamins, did the biological mother take any prescription medications during the pregnancy? Yes ☐ No ☐

If yes, what medications? _____

Why was this prescribed? _____

Who was the prescribing physician? _____

Did the child's mother have any of these problems during her pregnancy?

Toxemia or pre-eclampsia: Yes ☐ No ☐ High blood pressure: Yes ☐ No ☐

Anemia (low iron): Yes ☐ No ☐ Gestational diabetes: Yes ☐ No ☐

Did she have any other medical problems during pregnancy? Yes ☐ No ☐

CHILD INTAKE INFORMATION

Please specify _____

_____

How much did she smoke during pregnancy?

Not at all ☐ 1-5 cigarettes/day ☐ 5-10 cigarettes/day ☐ 10-20 cigarettes/day ☐

1-2 packs/day ☐ More than 2 packs/day ☐

How much did she drink during pregnancy?

Not at all ☐ 1-2 drinks/week ☐ 1-2 packs/day ☐ More than 2 drinks/day ☐

Occasional binges ☐ How many _____

Did she do other drugs (e.g., marijuana, crack, etc.) during pregnancy? Yes ☐ No ☐

Please specify _____

Beside the normal mood swings of pregnancy, did she experience any emotional or psychiatric problems during pregnancy? Yes ☐ No ☐

Please specify _____

_____

CHILD INTAKE INFORMATION

Birth

Was the child born prematurely? Yes ☐ No ☐ If yes, by how many weeks? _____

Was the child born late? Yes ☐ No ☐ If yes, by how many weeks? _____

How much did the child weigh at birth? _____ lbs

Did the child have any of these problems at birth?

Fetal distress ☐ Meconium aspiration ☐ Cord tight around neck ☐

Jaundice requiring treatment with lights ☐ Difficulty breathing ☐ Seizures ☐

Other problems _____

Did the child receive any of these treatments at birth?

Oxygen ☐ How long? _____

Ventilator or respirator ☐ How long? _____

Transfusion ☐ Reason _____

Surgery ☐ Reason _____

Other treatments _____

Did the baby go home with parent from the hospital? Yes ☐ No ☐

If no, how long did the baby stay in the hospital? _____

CHILD INTAKE INFORMATION

Infancy and early childhood

As an infant, did child:

Require very little sleep?	No ☐	Somewhat ☐	Quite a lot ☐
Seem excessively sleepy and unresponsive?	No ☐	Somewhat ☐	Quite a lot ☐
Have trouble gaining weight?	No ☐	Somewhat ☐	Quite a lot ☐
Seem to cry all the time?	No ☐	Somewhat ☐	Quite a lot ☐
Seem very sensitive to loud noises?	No ☐	Somewhat ☐	Quite a lot ☐
Seem to "move all over the crib?"	No ☐	Somewhat ☐	Quite a lot ☐
Walk before 11 months old?	No ☐	Somewhat ☐	Quite a lot ☐
Have difficult making changes (e.g., eating new food, sleeping away from home)?	No ☐	Somewhat ☐	Quite a lot ☐
Hang their head?	No ☐	Somewhat ☐	Quite a lot ☐
Was it difficult to please the baby?	No ☐	Somewhat ☐	Quite a lot ☐

When a toddler, did child:

Always run and not walk?	No ☐	Somewhat ☐	Quite a lot ☐
Get into everything in the house?	No ☐	Somewhat ☐	Quite a lot ☐
Always run away from you?	No ☐	Somewhat ☐	Quite a lot ☐
When the child was a preschooler, was it very difficult to control and manage child's behavior?	No ☐	Somewhat ☐	Quite a lot ☐

CHILD INTAKE INFORMATION

Was child:

Speaking 20 words by 18 months of age?	No ☐	Somewhat ☐	Quite a lot ☐
Saying their own name by two years of age?	No ☐	Somewhat ☐	Quite a lot ☐
Speaking three to six-word sentences by age three?	No ☐	Somewhat ☐	Quite a lot ☐
At age two, could others understand the child's speech?	No ☐	Somewhat ☐	Quite a lot ☐

At about what age (i.e., the nearest month) did the child do each of the following?

Sit up	Years _____	Months _____
Crawl	Years _____	Months _____
Stand alone	Years _____	Months _____
Walk by self	Years _____	Months _____
Dress self (with supervision)	Years _____	Months _____
Speak first real word	Years _____	Months _____
Speak first real sentence	Years _____	Months _____
Become completely toilet trained	Years _____	Months _____
Urine, day	Years _____	Months _____
Urine, night	Years _____	Months _____
Bowel	Years _____	Months _____
Help with household tasks	Years _____	Months _____
Ride a tricycle	Years _____	Months _____
Ride a bicycle (to nearest month)	Years _____	Months _____

CHILD INTAKE INFORMATION

Tie own shoes Years _____ Months _____

Medical and psychiatric problems

Has the child ever had any of the following?

Fever of 104 or more for 3 or more days	Yes ☐	No ☐
Anemia (low iron)	Yes ☐	No ☐
Sickle cell anemia	Yes ☐	No ☐
Frequent ear infections	Yes ☐	No ☐
Were tubs inserted?	Yes ☐	No ☐
Allergies to food	Yes ☐	No ☐
Other allergies	Yes ☐	No ☐
Difficulty sucking	Yes ☐	No ☐
Spells of vomiting	Yes ☐	No ☐
Asthma	Yes ☐	No ☐
Frequent headaches	Yes ☐	No ☐
Frequent stomach aches	Yes ☐	No ☐
Seizures/convulsions	Yes ☐	No ☐
Muscle tics/twitches	Yes ☐	No ☐
Lead ingestion	Yes ☐	No ☐
Operations	Yes ☐	No ☐

If yes, type _____

CHILD INTAKE INFORMATION

Fracture or serious injury Yes ☐ No ☐

If yes, type _____

Blow on head resulting in loss of consciousness or vomiting Yes ☐ No ☐

HIV positive Yes ☐ No ☐

Diabetes Yes ☐ No ☐

Other chronic disease Yes ☐ No ☐

If yes, type _____

Repeated/prolonged hospitalization Yes ☐ No ☐

If yes, reason _____

Does child take any medications Yes ☐ No ☐

If yes, specify _____

Has the child ever been involved with the police, or juvenile court? Yes ☐ No ☐

Has child even been hospitalized for psychiatric reasons? Yes ☐ No ☐

Has there ever been a protective services case open related to this child? Yes ☐ No ☐

Has anyone in the family had any of these problems?

☐ Depression or excessive sadness Who _____ When _____

☐ Anxiety or nervousness Who _____ When _____

☐ Suicide attempts/suicides Who _____ When _____

☐ Alcoholism Who _____ When _____

CHILD INTAKE INFORMATION

☐ Drug abuse Who _____ When _____

☐ Retardation Who _____ When _____

☐ Obsessive compulsive disorder Who _____ When _____

☐ Epilepsy Who _____ When _____

☐ Schizophrenia Who _____ When _____

☐ Bipolar disorder (manic-depressive) Who _____ When _____

☐ ADHD or hyperactivity Who _____ When _____

☐ Learning problems Who _____ When _____

Current concerns

Has the child received any of the following treatments?

☐ Ritalin Dose _____ When _____

☐ Dexedrine Dose _____ When _____

☐ Other psychiatric medication Dose _____ When _____

Name(s) _____

☐ Counseling/therapy

If yes, name of therapist _____

Does the child have any of these toileting problems?

Problems staying dry during the day? Yes ☐ No ☐

Problems staying dry at night? Yes ☐ No ☐

CHILD INTAKE INFORMATION

Problems with soiling (Encopresis)?	Yes ☐	No ☐
If yes, number of times _____ Daily ☐ Weekly ☐		
Does this child ever talk about self-harm?	Yes ☐	No ☐
Has this child ever attempted suicide?	Yes ☐	No ☐
Is there a lot of stress in the family?	Yes ☐	No ☐
Is there a lot of conflict in the family?	Yes ☐	No ☐
Has anyone in the family had trouble with the law or police?	Yes ☐	No ☐
Has there been a separation or divorce?	Yes ☐	No ☐
If separated/divorced, are there any problems with custody or visitation?	Yes ☐	No ☐
If divorced, have spouses remarried?	Yes ☐	No ☐
Has there been a recent death in the family?	Yes ☐	No ☐
Has there been a recent serious illness or hospitalization in the family?	Yes ☐	No ☐
Has anyone in the family seen a psychiatrist, psychologist, or counselor?	Yes ☐	No ☐
Did this child's bio-mother receive special education services in school?	Yes ☐	No ☐
Did this child's bio-father receive special education services in school?	Yes ☐	No ☐
Was anyone in the family have problems similar to this child when they were growing up?	Yes ☐	No ☐