Priscilla Klockner, MA
(503) 327-4839

Intake Information Client Under Age 12:

Today's Date: _____________ Form completed by: _________________________

Client Name ______________________________Gender___________ Birth date ______________ Age _________

Is your child ____ biological ___ foster _____ adopted ___ other: (describe) _____________________________

Address ____ City ___________________ State _____ Zip ___________

Father's name ____________________________________ Date of Birth _______________

Father Address _____________________________________City_________________ State _____ Zip ____________

Father Phone (day/work) ________________ (eve/home) _____________________ (cell) ___________________

May I leave a message for you at home? ☐ Yes ☐No Work? ☐ Yes ☐No Cell? ☐ Yes ☐No

Mother's name ____________________________________ Date of Birth _______________

Mother's Address _____________________________________City_________________ State _____ Zip __________

Mother's Phone (day/work) ________________ (eve/home) _____________________ (cell) _________________

May I leave a message for you at home? ☐ Yes ☐No Work? ☐ Yes ☐No Cell? ☐ Yes ☐No

Sibling name	Age	Does sibling live with client?
____________________________	_________	____
____________________________	_________	____
____________________________	_________	____
____________________________	_________	____

Others living in home with Client:

Name	Relationship
____________________________	____
____________________________	____
____________________________	____
____________________________	____

Emergency Notification __________________________ Relationship _______________ Phone ________________

Social Security # client ______________ Education/Year in School ___________________

Client Phone # (if different from above) ____________________May I leave a message for you? Yes ___ No ___

How did you hear about me? _____________________________________ Name __________________________

Address ______________________ Phone # ________________________ E-mail __________________________

____

Presenting Concerns

What is your main concern regarding this child at this time? ____

____

____

When did the problem(s) start?______________ Do they occur at Home?____ School?_____ Other: ________

Recent changes that may be contributory include____

____

____

Previous Evaluations | **Conclusions**

___________________________________ ___________________________________

___________________________________ ___________________________________

Past/Current Therapy | **Dates**

___________________________________ ___________________________________

___________________________________ ___________________________________

Pregnancy & Birth History

When did this child come into your home? Birth____ Adopted @ age_______________

Known substance exposures during pregnancy: ☐cigarettes ☐alcohol ☐drugs Describe:___________________

List any complications, illnesses, and/or accidents during pregnancy, labor, and/or delivery:________________

____

____

Birthweight ___________Gestational Age at birth ___________ Type of delivery: ☐vaginal ☐C-section

Describe your initial bonding experience with this child ____

____

Did mother experience the "baby blues" (postpartum depression)? ☐Yes ☐No If yes, did mother receive treatment? Yes___ No___ Describe____

Describe any prolonged separations from parent(s) during infancy _______________________________________

____

Social Development

What was this child like as an infant? ____

Did he/she make eye contact as an infant? ☐ Yes ☐No. Seek Interaction? ☐Yes ☐No

Did he/she demonstrate curiosity about the environment in the first three years? ☐ Yes ☐No

What were this child's favorite activities/toys in infancy and toddlerhood? __________________________________

____

Was there a time when you became worried that something wasn't quite right? ☐ Yes ☐No When was this?

____

Is there a history of separation anxiety? _________ Stranger anxiety? _______________

What is child's activity level in general? _____ High ______ Moderate _____ Low

How predictable is child's behavior? __Very predictable ___So-so ___Unpredictable

How does child tend to respond to something new? ☐Approaches ☐Withdraws ☐Watches

How does child transition/adapt to novelty or change? _____ Easily _____ With difficulty

How much stimulus is required before child reacts? _______A lot ______ A little

Describe the amount of happy, joyful behavior the child demonstrates in contrast to unhappy crying, whining behavior: ____

Do you find yourself "walking on egg-shells" with him/her? ____

Describe child's attention span: ☐ Long ☐ Moderate ☐ Short ☐Hyperfocus

Describe the child's persistence: does he/she continue working on a project despite obstacles or give up easily?

____

Is the child easily distractible? ☐ Yes ☐No Forgetful? ☐ Yes ☐No

How does this child interact with:

siblings? ____

peers? ____

adults? ____

Play Behaviors (check all that apply):

☐prefers to play alone
☐prefers to play alongside others
☐prefers to play cooperatively (fully engaged with others)
☐prefers to play with older children
☐prefers to play with younger children
☐cautious
☐accident-prone
☐controlling
☐aggressive
☐can't tolerate losing
☐difficulty taking turns
☐difficulty sharing
☐reckless

Does he/she have a favorite playmate (other than sibling)? If Yes who?_______________________________

Describe any concerns you have about his/her social skills or behavior ________________________________

____

What are his/her ***current*** favorite play activities? ____

Please indicate the hours per day of: TV ______ Computer______ Video Games______

Where does child live? ☐House ☐Apartment ☐With whom? _________________________

Describe the household: ☐chaotic ☐messy ☐orderly.

How much variation in his/her day? ☐A little ☐A lot ☐Varies How many times has he/she moved?______

Is the current neighborhood kid-friendly? ☐Yes ☐No __________________________________

Family support comes from: ☐Extended family ☐Neighbors ☐Friends ☐Church ☐Counselor

Describe any chores/household duties child is responsible for: _________________________________

Who is the primary disciplinarian? _______________ Is discipline inconsistent? ☐Yes ☐No If no, why not?
____

Describe form of discipline used _____________________________Child's response __________________________

Trauma Exposure

Natural disaster ____

Loss of a parent/significant other ____

Domestic violence ____

Abuse/Neglect/Abandonment ____

Motor Development

Sat alone @_________ Crawled/Creeped @ _________Walked alone @ _______Picked up small items @_________

Undressed self @ _________ Dressed self @ __________

Current motor skills: ☐Agile ☐Coordinated ☐Clumsy ☐ Awkward ☐ Accident prone

Describe: ____

Describe concerns you may have about this child's fine or gross motor development : _______________________

____

Hand dominance: ☐ R ☐L ☐Neither Activity Level: ☐Very High ☐ High ☐Moderate ☐Low

Speech/Language Development

Primary language ___________Spoke 1st word @__________Does child gesture? ______ Use sign language? ____

How does the child let you know what he/she wants or needs? ____

How does the child show that he/she understands what you say? ____

What percentage of this child's speech do you understand? ☐25% ☐50% ☐75% ☐100%

What percentage do unfamiliar listeners understand? ☐25% ☐50% ☐75% ☐100%

Past/Current Speech Therapy: ____

Feeding development

Describe any feeding difficulties (past/present) ____

____

Current appetite: ☐poor ☐fair ☐good Eating behaviors:☐picky ☐overeats ☐refuses to eat ☐hoards food ☐gags/Vomits ☐eats non-food items Food preferences____

Does your family eat together at least once a day? ___________ Does the child remain seated at the table throughout the meal? ____

At present the child uses: ☐fingers ☐fork ☐spoon ☐bottle ☐sippy cup ☐open cup.

Special Diets (past/present) ____

Toileting/Hygiene Development

Is this child currently toilet-trained? ☐Yes ☐No If yes, since what age? _________☐diaper☐pull-ups ☐panties ☐daytime accidents? ☐bedwetting?

Did the child toilet train easily? ___________ Describe: ____

Please check all that apply: ☐constipation ☐frequent loose stools

Describe any resistance to regular hygiene routines (bathing, hair wash, toileting, care of teeth, etc.)_
____

____

Sleep development

Where does the child sleep? ☐solo (own bed) ☐with parent ☐with sibling

Does he/she sleep in a room alone or share a room with sibling/other? ______________

Bedtime ____________ Average number of hours of sleep/night? ___________________

How does he/she wake up? ☐slowly/reluctantly ☐quickly/eagerly

Naps? ___________ If yes, for how long ____

Sleep Disturbances: (check all that apply)

☐reluctance to go to bed ☐difficulty in getting to sleep

☐restless during the night ☐talks/cries in sleep

☐bad dreams ☐snoring/irregular breathing

☐frequent waking ☐difficulty getting up in morning

Describe any other concerns relating to sleep behaviors: ____

Medical History

General state of child's health____

Primary care physician's name:___________________________________

Address____Phone#________________________

Fax#___________________________Date of last well child exam ____________________

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Please describe any concerns or problems related to child's hearing and/or vision:___________________________

____

Check all medical issues that apply to your child:

	Current?		Current?
☐recurrent ear infections		☐urinary tract infections	
☐lung infections		☐headaches	
☐head injury		☐seizures	
☐stomach aches		☐high pain tolerance	
☐stitches		☐ other health problems? Describe: _________________	
☐general aches/pains			

Is the child exposed to second-hand smoke? ☐inside ☐outside ☐in the car

List any environmental/food allergies: ____

List any <u>medication</u> allergies: ____

Describe reason for any ***overnight*** hospitalizations: ____

Are immunizations up-to-date? ☐ Yes ☐ No If No please describe:____

____

Current prescription medication/ Over the counter medications/ Herbal remedies / Nutritional Supplements:

Name	Dosage/Frequency	Purpose	Prescribing/Recommending Provider's name
__________________	______________	__________________	_________________________________
__________________	______________	__________________	_________________________________
__________________	______________	__________________	_________________________________
___________________	______________	__________________	_________________________________

Family Medical History

Does this child remind you of someone in the family? ☐Yes ☐No Who? ___________________________________

Why? ____

Please indicate those family members – parents, grandparents, siblings, aunts or uncles, first cousins – who currently have or have had the following health problems:

	How is family member related?	Current		How is family member related?	Current
Thyroid Disease		☐	Anxiety		☐
Anemia		☐	Depression		☐
Liver Disease		☐	Bipolar (Manic/depression)		☐
Kidney Disease		☐	ADHD/ADD		☐
Heart Disease		☐	Autism/Asperger Disorder		☐
Diabetes		☐	Schizophrenia/Psychosis		☐
Asthma		☐	Speech Problems		☐
Stomach Intestinal		☐	Learning Disability		☐
Problems		☐	Seizure Disorder		☐
Cancer		☐	High Cholesterol		☐
Epilepsy		☐	High Blood Pressure		☐
Pain		☐	Other:_________________		☐

Daycare/Preschool/Academic History

When was this child out of maternal care for the first time? ____

____

List location and child's age at time of attendance for the following:

Child care ____

Preschool ____

Grade School ____

What have been this child's response(s) to day care/school ?
____

____

Is this child on an IEP? ☐ Yes ☐ No ______ If Yes (describe): ____

____

Describe the child's academic performance (strengths and challenges): _____________________________________

____

Is this child frequently late to or absent from school? ☐ Yes ☐ No If Yes, why? __________________________

____

What extracurricular activities does the child participate in? ____

Describe book sharing/reading experiences ____

____

____ ___________________________________
Signature Date

Thank you for taking the time to fill out this form as completely as possible!