Intake Questionnaire

Please print clearly and complete all items. Write N/A for items that do not apply to you. Note any item(s) that you are unsure how to answer. The psychologist/clinician will review the form with you and answer any questions during the initial interview.

First and last name of person completing form: ______________________________

Relationship to client: ____________________ Date of completion: ____________________

Reason for Referral

Who referred you, or how did you find us? ______________________________

What type of services are you seeking?

O Assessment O Consultation O Individual Therapy O ABA Therapy O Unsure

What are your concerns? (please use additional page(s) if needed) ______________________________

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How long have you had these concerns? ______________________________

Do any of your family members or relatives have a similar problem? O Yes O No If yes, please note relation to client and age (if known) ______________________________

What are your primary goals for this consultation or evaluation?

1. ______________________________
2. ______________________________
3. ______________________________

Client/Child Information

Last Name: ____________________ First Name: ____________________ Middle Initial: ________

Nickname: ____________________ Gender: O Male O Female

Date of Birth: ____________________ Place of birth: ____________________
month / day / year city / state

Address: ______________________________
street / city / state / zip code

County of Residence: ____________________ School District of Residence: ____________________

Primary Phone: (_____) ____________________ E-mail: ____________________

Confidential voicemail? O Yes O No

With whom does the client live? ____

Educational Setting: O Public O Charter O Private O Homeschool O Daycare O N/A

Individualized Education Plan? O Yes* O No Educational Eligibility Category(s): ______________________________
*If yes, please include copies of most recent MET and IEP reports.

School / Daycare Name(s): ____

School District: ____

Grade: ____________ Teacher(s) / Instructor(s) Name: ____

Client's Employment Status: O Employed O Unemployed O Never Employed

If employed or unemployed, list current or former employer: ____

Parent/Guardian Information

Parent/Guardian 1: O Biological parent O Adoptive parent O Stepparent O Guardian O Other

Name: ____ Date of Birth: ______________________________
☐ check here if contact information is the same as client's, and if so, skip directly to e-mail

Address: ____
street / city / state / zip code

County of Residence: ________________________________ Home Phone: (_____) ___________________________

E-mail: ____ Cell Phone: (_____) ___________________________

Occupation (if applicable): ____________________________ Work Phone: (_____) ___________________________

Highest level of education completed: ____

Parent/Guardian 2: O Biological parent O Adoptive parent O Stepparent O Guardian O Other

Name: ____ Date of Birth: ____________________________
☐ check here if same address as Parent/Guardian 1 and skip to e-mail

Address: ____
street / city / state / zip code

County of Residence: ________________________________ Home Phone: (_____) ___________________________

E-mail: ____ Cell Phone: (_____) ___________________________

Occupation (if applicable): ____________________________ Work Phone: (_____) ___________________________

Highest level of education completed: ____

Parent/Guardian Relationship Status:

O Married O Domestic Partners O Long-term relationship O Divorced O Separated O Never married

Additional Parent(s)/Guardian(s): O Adoptive parent(s) O Stepparent(s) O Guardian(s) O Other

Name: ______________________________ Date of Birth: ______________________

Address: ____
street / city / state / zip code

County of Residence: ______________________ Home Phone: (_____) ______________________

E-mail: ______________________________ Cell Phone: (_____) ______________________

Occupation (if applicable): ______________________ Work Phone: (_____) ______________________

Highest level of education completed: ______________________________________

Siblings: List all full, half, stepbrothers and sisters of child, in birth order.

Name	Gender	Age	Relationship to Child/Client	Live in Home
				O Yes O No
				O Yes O No
				O Yes O No
				O Yes O No
				O Yes O No
				O Yes O No

Other individuals living in the household: O Yes O No

If yes, list names and relationship to the child. ______________________________________

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Family History

Describe any history of developmental delays, learning difficulties, behavioral challenges, mental health disorders, and/or medical conditions in family members: ______________________________________

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Developmental History

Did mother use any of the following during pregnancy?

Tobacco: O Yes O No O Unknown If yes, frequency: O Occasionally O Daily O Weekly O Unknown
Alcohol: O Yes O No O Unknown If yes, frequency: O Occasionally O Daily O Weekly O Unknown
Drugs: O Yes O No O Unknown If yes, frequency: O Occasionally O Daily O Weekly O Unknown

Planned pregnancy? O Yes O No
Natural conception? O Yes O No If no, please note procedure used: ____________________

Length of pregnancy:____________________ Birth weight: ____________________

Delivery method (e.g., C-section): ____________________

Describe any difficulties or complications during pregnancy and/or delivery/post-delivery:____________________

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Developmental Milestones
List age (in months) at which your child did the following:
Check one: O Approximated O Exact

Motor	Language
Sat alone: ____________	Babbling/Cooing: ____________
Crawled: ____________	First Words: ____________
Stood alone: ____________	Combined 2 words: ____________
Walked alone: ____________	Used 3-4 word sentences: ____________

Please indicate any difficulties your child has had with the following:

Toileting: O Current O Past O Never If ever, describe: ____________________
Eating: O Current O Past O Never If ever, describe: ____________________
Sleeping: O Current O Past O Never If ever, describe: ____________________

Medical & Behavioral Health History of Child/Client (Please use additional page if needed)
Primary Care Physician: O Yes O No

Name: ____________________ Specialty: ____________________

Address: ____________________
street / city / state / zip code
Phone: (_____) ____________________

Other Healthcare Provider(s): O Yes O No

Name: ____________________ Specialty: ____________________

Address: ____________________
street / city / state / zip code
Phone: (_____) ____________________

Name: ____________________ Specialty: ____________________

Address: ____________________
street / city / state / zip code
Phone: (_____) ____________________

Allergies, medical conditions, and/or mental health disorders? O Yes O No If yes, explain: ______________________

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Serious illnesses or hospitalizations? O Yes O No If yes, explain: ______________________________

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List any medication or supplements child/client is receiving: (Please use additional pages, if needed)

Medication	Dosage	Time(s) given

Describe your child's eating habits: ____

Special diet and/or food allergies? O Yes O No If yes, explain: ______________________________

____

Social-Emotional & Behavioral History

Please indicate if you have concerns related to any of the following issues with your child/client, either currently or in the past:

O Does not follow instructions
O Difficulty paying attention
O Excessive crying/tantrums
O Difficulty interacting with peers
O Withdrawn/avoids interactions
O Unusual/repetitive behaviors
O Rigid behavior, routines, rituals
O Unhappy/sad
O Moody/irritable
O Anxious/worries
O Hypo-/hypersensitive to any of senses
O Harm to other people or animals
O Self-injurious behavior
O Preoccupations, obsessions
O Acts without thinking
O Overactive
O Underactive/lacks energy
O Excessive fears
O Overly familiar with strangers
O Unaware of environmental dangers
O Sexually precocious behavior

Has your child/client experienced any of the following?

O Move to a new home/school
O Death in the family
O Serious illness of family member
O Bullying
O Family financial stress
O Witnessed abuse
O Experienced abuse
O Neglect
O Parent separation/divorce
O Parental conflict
O Incarcerated parent
O Traumatic event

Previous Evaluations O Yes* O No

*If yes, please include copies of most recent MET and IEP reports.

Date (month/year)	Evaluator (name, credentials)	Facility (e.g., name of clinic)	Reason for Testing (e.g., delayed speech)
____________	_________________________	______________	_________________________________
____________	_________________________	______________	_________________________________
____________	_________________________	______________	_________________________________
____________	_________________________	______________	_________________________________
____________	_________________________	______________	_________________________________
____________	_________________________	______________	_________________________________
____________	_________________________	______________	_________________________________
____________	_________________________	______________	_________________________________

Educational History

List all schools attended, including preschool and/or daycare.

School/Facility Name	Type of Classroom (e.g., multi-age/grade, mainstream, integrated, self-contained, etc.)	Grade(s) (indicate if repeated)	Dates Attended (month/year – month/year)
______________________________	_________________________	___________	__________________
______________________________	_________________________	___________	__________________
______________________________	_________________________	___________	__________________
______________________________	_________________________	___________	__________________
______________________________	_________________________	___________	__________________
______________________________	_________________________	___________	__________________
______________________________	_________________________	___________	__________________

Ever suspended or expelled? O Yes O No If yes, what grade(s)? _____________________________________

Explain incident & consequence/resolution: ____

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Services Received (Include current and previous services)

Type of Service (speech therapy)	Location (clinic, home, school)	Provider (name, credentials)	Duration/Frequency (60 min/wk)	Dates (6/10 – present)

Extracurricular / Group Activities (include social groups, clubs, sports teams, etc.)

Activity (e.g., soccer)	Organization/Location (city league)	Duration/Frequency (2hrs; 2x/week)	Dates (6/10 – present)

Community Organizations Resources

Does the client or your family participate in other community-based programs or resources? (e.g., religious group, support group, social services, etc.) O Yes   O No   If yes, please list: ____

____

Strengths of the Child/Client and Family

Please tell us about your/your child's and family's strengths: ____

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Please tell us anything else you think would be helpful in understanding you or your child. Include any questions you may have.

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Thank you for taking the time to complete this questionnaire!

By signing this form, I attest the information provided is true and accurate to the best of my knowledge.

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printed name   signature   date