Conservatorship/Guardianship, SILS/ILS, AFC, Waivered Services, Adult Mental Health Targeted Case Management, ARMHS, CTSS, Psychology/Therapy, Chemical Health Services, Medication Management, Housing Stabilization Services, Social Security Advocacy

101 21st St. SE Phone: 507-437-6389

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 Email: info@imsofmn.com

**CHILD INTAKE QUESTIONNAIRE**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Child’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Child’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name/Relation of person completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Ethnicity: 🞏 White/Caucasian 🞏Hispanic/Latino 🞏 Black/African-American 🞏 Asian

 🞏Pacific Islander/Native Hawaiian 🞏 American Indian or Alaska Native 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender Identity: 🞏 Male 🞏 Female 🞏 Transgender 🞏 Non-binary

Parent/Guardian Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_

***\*Please bring a copy of custody agreement if applicable\****

**Contact Phone Numbers (please include name/relation to child and indicate primary contact name/number)**

**Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relation to the Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Contact Name/Relation) (Phone)

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Contact Name/Relation) (Phone)

**Please list members of the of the household where the child currently lives:**

|  |  |  |
| --- | --- | --- |
| Name | Relationship | Age |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Please list family members not living in the home (siblings, parents, etc.):**

|  |  |  |
| --- | --- | --- |
| Name | Relationship | Age |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

How did you hear about IMS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your main concerns at this time and why are you seeking services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child been hospitalized: 🞏Yes 🞏No

If yes, when and why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please list any social workers, therapists, county workers, or other professionals currently involved in the child’s care:**

1. Name/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Name/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Name/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If the child has any previous mental health diagnosis, please list below:**

|  |  |  |
| --- | --- | --- |
| Diagnosis | Who Diagnosed | When |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Current Medications (Including vitamins, herbs, and supplements):**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of medication | Dosage | Frequency | Purpose |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Does the child have any allergies (including to medications, environmental, other)? 🞏Yes 🞏No

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are there any medications the child has been told to avoid? 🞏Yes 🞏No

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does the child drink alcohol? 🞏Yes 🞏No

If yes, how much and how often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child smoke cigarettes/e-cigs or use other nicotine products? 🞏Yes 🞏No

If yes, which and how much: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the child ever done illicit drugs or abused prescription medications? 🞏Yes 🞏No

If yes, what did they use and when was their last use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the child ever been to jail? 🞏Yes 🞏No Has the child ever been homeless? 🞏Yes 🞏No

Please explain any current or ongoing medical conditions the child has that we should be aware of:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Prenatal History:**

I the child adopted? 🞏Yes 🞏No If yes, at what age? \_\_\_\_\_\_\_\_\_\_ Country of origin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for adoption? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any problems, complications, or accidents during this pregnancy (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Number of pregnancies before this birth: Live: \_\_\_\_\_ Miscarriage: \_\_\_\_\_\_ Still birth: \_\_\_\_\_ Total:\_\_\_\_\_

**Did the mother use any of the following while pregnant:**

Alcohol 🞏Yes 🞏No If yes, during what month(s) of pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cigarettes 🞏Yes 🞏No If yes, during what month(s) of pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine 🞏Yes 🞏No If yes, during what month(s) of pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drugs 🞏Yes 🞏No If yes, which and during what month(s) of pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Labor & Birth Information:**

The child was born: 🞏On time 🞏\_\_\_\_\_ weeks early 🞏\_\_\_\_\_ weeks late

Birth weight: \_\_\_\_\_ Pounds \_\_\_\_\_ Ounces Birth height: \_\_\_\_\_ inches

Were there problems or concerns during labor/delivery: 🞏Yes 🞏No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How was the baby delivered: 🞏Normal vaginal birth 🞏Breech 🞏Forceps vacuum extraction 🞏C-section

If C-section, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Did the baby have any special care after delivery (check all that apply):**

🞏With breathing/oxygen 🞏Blood transfusion 🞏Neo-natal intensive care 🞏Infection care/antibiotics

🞏Seizure Care 🞏Heart monitoring 🞏Poor feeding 🞏Body temperature regulation 🞏X-rays

🞏Drug withdrawal 🞏Jaundice/bili-lights 🞏Non-responsive 🞏Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where was the baby born (hospital name/city/state): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Early Childhood Health & Development (Birth – 18 months)**

How was the baby fed: 🞏Breast fed (\_\_\_\_\_ months) 🞏Bottle fed (\_\_\_\_\_ months)

Please describe any feeding or eating problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**The baby was:**

🞏Easy – didn’t cry much, slept and ate on schedule, cuddly, easy to soothe

🞏Average – mostly easy but occasional fussing

🞏Sensitive – easily upset, best with a fixed schedule

🞏Difficult – hard to satisfy, fussy, did not eat/sleep on schedule, colicky

**Milestones – When did your child do the following?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Most Children | Early | Normal | Late | Do not recall |
| Roll over without help | 4 – 6 months |  |  |  |  |
| Crawl | 9 – 12 months |  |  |  |  |
| Sit without support | 6 – 9 months |  |  |  |  |
| Walk without help | 12 – 15 months |  |  |  |  |
| First words | 9 – 12 months |  |  |  |  |
| Liked to color | 9 – 12 months |  |  |  |  |
| Use 2 words i.e. (“me go”) | 18 – 24 months |  |  |  |  |
| Tie shoe laces | 4 – 6 years |  |  |  |  |
| Speak in sentences | 2 – 3 years |  |  |  |  |

Was any part of toilet training difficult? 🞏Yes 🞏No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child still have issues with toileting? 🞏Yes 🞏No

If yes, please explain (i.e. bed-wetting): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

The child’s health is: 🞏Excellent 🞏Good 🞏Fair 🞏Problematic

If problematic, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Who is the child’s primary care doctor (include clinic name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you concerned about the child’s eating habits/diet: 🞏Yes 🞏No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you concerned about the child’s sleep habits: 🞏Yes 🞏No

If yes, please explain (include bedtime/wake up time): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**School & Education History**

|  |  |  |
| --- | --- | --- |
|  | School Name/Location | Specific problems/concerns |
| Pre-School |  |  |
| Kindergarten |  |  |
| Grade 1 |  |  |
| Grade 2 |  |  |
| Grade 3 |  |  |
| Grade 4 |  |  |
| Grade 5 |  |  |
| Grade 6 |  |  |
| Grade 7 |  |  |
| Grade 8 |  |  |
| Grade 9 |  |  |
| Grade 10 |  |  |
| Grade 11 |  |  |
| Grade 12 |  |  |

Does the child currently have an IEP? 🞏Yes 🞏No

Is the child served under Section 504-Accomodation Plan? 🞏Yes 🞏No

Has the child ever been suspended from school? 🞏Yes 🞏No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the child ever been expelled from school? 🞏Yes 🞏No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Environment**

How easily does the child made friends? 🞏Below average 🞏Average 🞏Above average

How long does the child usually keep friends? 🞏Not long 🞏Average 🞏Years

How many close friends does the child have? 🞏None 🞏1 🞏2 -3 🞏Lots

The child picks friends who are… 🞏”Good kids” 🞏Negative influences 🞏similar to them 🞏”Needy”

**How well does the child get along with…**

Siblings 🞏Well 🞏Average 🞏Poorly

Other kids the same age 🞏Well 🞏Average 🞏Poorly

Older kids 🞏Well 🞏Average 🞏Poorly

Younger kids 🞏Well 🞏Average 🞏Poorly

Teachers 🞏Well 🞏Average 🞏Poorly

Other adults 🞏Well 🞏Average 🞏Poorly

**Use the space below if you would like to include additional information:**