



Child and Family Intake (Children 12 and under):

Date: _____

Child's Name: _____ Date of Birth: _____ Age: _____

Parent 1's Name: _____ Age: _____ Occupation: _____

Parent 2's Name: _____ Age: _____ Occupation: _____

Marital Status: _____ Home Phone: _____

Parent 1's Cell phone: _____ Parent 2's Cell phone: _____

Parent 1's Work phone: _____ Parent 2's Work phone: _____

Emergency Contact (Name & Phone): _____

Is it okay to leave a message at all these numbers? Yes: ___ If not, which if any? _____

Sibling's Name: _____ DOB: _____ Age: _____

Sibling's Name: _____ DOB: _____ Age: _____

What concerns if any do you have about your child? _____

What have you done to address the concern(s) so far?

Have any professionals been consulted (include any previous assessments, reports, etc.):

Primary Pediatrician: _____

Developmental Pediatrician: _____ Phone: _____



Neurologist: _____ Phone: _____

Other: _____

Developmental History:

Adoption:

Is your child adopted? Does he or she know they are adopted? _____

Pregnancy and Delivery:

Length: _____ months? Was the timing of the pregnancy good for you? _____

Any complications during pregnancy? _____

Any medications taken during pregnancy? _____

How did you feel about the pregnancy? _____

How did your Partner/spouse feel about the pregnancy? _____

What was your mood during pregnancy? _____ And after? _____

Type of delivery? _____ Birth Weight? _____ Complications? _____

Emotional reaction to child? _____

Baby's temperament? _____

Breast-fed? _____ Bottle-fed? _____ How did weaning go? _____

Problems with feeding? _____ Problems with sleeping? _____

Problems in the marital relationship? _____

Developmental Milestones:

Sat up at _____ Crawled at _____ Walked at _____



First words _____ Spoke in sentences _____

Toilet training accomplished (yes/no) _____ at _____ Difficulties? _____

Medical History:

Chronic Illness _____ Hospitalization _____ Surgeries _____

Ear infections _____ Strep _____ Allergies _____ Asthma _____

Other _____

Family History:

Have any immediate or extended family members experienced any of the following:
(Circle all that apply)

Anxiety Bi-Polar Disorder

Depression ADD/ADHD

Alcohol/Substance Abuse Schizophrenia/Psychotic Disorder

Childcare or Preschool:

Preschool _____ Telephone _____ Director _____

Teacher _____ Time/Days _____

Age started _____ Reaction to separation/and process _____

Relationship with teachers/caregivers _____ With other children _____

Concerns of teachers/caregivers _____

General:

Does your child either seek-out, avoid, or over-react to: noises? _____ bright lights? _____

touch? _____ smells? _____ food textures? _____ clothing? _____

movement? _____



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PSYCHOLOGIST

Have there been any long separations, losses, exposure to extreme family conflict or traumas, etc. in your child's life? Please describe: _____

Please describe your child's personality: _____

Please describe your child's relationship to you:
Parent 1 _____

Parent 2 _____

Describe your parenting style. What is your attitude toward discipline and structure?
Parent 1 _____

Parent 2 _____

Describe your comfort level with an expression of a range of feelings:
Parent 1 _____

Parent 2 _____

How well do you and your partner co-parent together?
Parent 1 _____

Parent 2 _____

What does your child like to do? _____



What does your child not like to do? _____

Describe your child's ability to handle:
Separations _____

New situations and people _____

Frustration _____

Limit Setting _____

Transition times _____

Expressing him/herself emotionally _____

Soothing him/herself _____

Recovery from distress _____

Self-Care (dress, feed, brush teeth, use toilet, etc.) _____

Do you have concerns in the following areas:

Making eye contact _____

Answering to his/her/their name _____

Arching back when being held _____

Excessive crying _____

Not pointing or mutually engaging _____

Fine motor skills _____ Gross motor skills _____

Sleeping _____

Eating _____



Aggression _____

Behavioral concerns _____

Temper tantrums _____

Social interactions with peers _____

Social interactions with adults _____

Passivity or lack of interest in things _____

Other _____

At approximately what age did your child begin to...Point at things _____

Coo and babble _____ First words _____ Name things _____

Combine two words _____ Use short sentences _____

Ask questions _____ Answer questions _____

Imitate movements _____ Identify needs _____

Please describe your child's feeding and eating development (picky eater, aversions, chewing or swallowing difficulties or allergies):

