Intake Forms and Parent Questionnaire

This packet is to be completed by testing patients for Dr. Fraser prior to the first testing appointment.

Patient's Name: _____ Date of Birth: _____

Gender: _____ Date Form Completed: _____

Mailing Address: _____

_____

Primary Phone Number: _____ May we leave a message? _____

Form Completed By: _____

If the person completing this form is not the biological parent, please explain: _____

_____

_____

Who were you referred by? _____

Primary Care Physician: _____ Phone:_____

Insurance Company: _____ Policy Number:_____

Subscriber Name: _____ Subscriber SSN: _____

Mother Name: _____ Age:_____

Phone Number: _____ Email Address: _____

Highest Level of Education: _____

Occupation: _____

Father Name: _____ Age:_____

Phone Number: _____ Email Address: _____

Highest Level of Education: _____

Occupation: _____

With whom does the child live? _____

If the child is living with **another** primary caregiver:

Caregiver Name: _____ Age:_____

Phone Number: _____ Email Address: _____

Highest Level of Education: _____

Occupation: _____

If parents are separated/divorced, what is the current custody/visitation agreement?

_____

Primary Language Spoken: _____ Other Languages: _____

Does your child have any siblings? _____

Sibling Name: _____ Age: _____

Gender: _____ Full/Half/Step Sibling? _____

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Gender: _____ Full/Half/Step Sibling? _____

Has your child previously been assessed including being seen by a previous psychologist, Early Steps, Child Find, or school testing? _____

_____

General Concerns

What are your primary areas of concern for your child? _____

_____

_____

How long have these behaviors been a concern? _____

_____

_____

What are you hoping to achieve or learn through this process? _____

_____

_____

_____

Developmental History

At what age were you first worried about your child's development? _____

_____

What is your child's current language level (e.g., nonverbal, single words, phrases, full sentences)? _____

At what age did your child do the following:

Crawl _____months Stand Alone _____months Walk Alone _____months

Babble _____months Say First Words _____months

Use Two-Word Phrases _____months

Is your child able to follow one-step directions? _____

Two-step? _____

Multi-step? _____

Is your child toilet trained? _____

If your child has siblings, was his/her development different in any way? _____

_____

Medical/Birth History

Gestational Age: _____ Birth Weight: _____ lbs _____ oz

Birth Location: _____

Type of Delivery (vaginal or caesarian section)? _____

APGAR Scores (if known): _____

Were any prescription medications used during pregnancy (please list)? _____

_____

Were any drugs or alcohol used during pregnancy (please list)? _____

_____

Were there any complications during birth (e.g., use of forceps, fever at birth, breech, etc.)? _____

_____

Has your child had any other serious illnesses, injuries, or other health problems (e.g., seizures, jaundice, asthma, feeding difficulties, poor muscle tone)? _____

_____

Does your child have any allergies? _____

_____

Has your child ever been hospitalized? If so, please explain? _____

_____

What is the date of your child's last physical examination? Any significant results?

_____

What is the date of your child's last vision screening? What were the results? _____

_____

What is the date of your child's last hearing screening? What were the results? _____

_____

Current Medications (name, dosage, frequency): _____

_____

Previous prescription medications (name, dosage, frequency): _____

_____

Has your child ever abused drugs or alcohol? If so what substance(s)? _____

_____

What time does your child generally go to sleep? _____

What time does he/she awake in the morning? _____

Does your child have any sleep difficulties (e.g., frequent night terrors, difficulty falling/staying asleep?) _____

_____

Does your child eat a variety of foods/textures? _____

_____

Family History

Please indicate if anyone in your family has ever had any of these conditions (if so, please specify which family member, such as "mother", "maternal grandmother", "sister").

	Family Member(s)
Delayed walking:	
Delayed talking:	
Speech problems/therapy:	
Learning problems:	
Intellectual disability:	
Autism spectrum disorder:	
ADHD:	
Seizures:	
Cerebral palsy:	
Depression/Anxiety:	
Bipolar disorder:	
Schizophrenia:	
Mental Illness (other):	
Blindness/Visual impairment:	
Deafness/Hearing impairment:	
Death before age 50:	
Heart problems:	
Congenital heart disease:	

Stroke:	
Diabetes:	
Alcoholism or Drug Addiction:	

Education/Intervention History

Does/did your child receive any early intervention services (i.e., Early Steps)? _____

_____

Current School: _____ Current Grade: _____

Has your child even been retained? If yes, what in what grade? _____

Does/did your child receive any therapeutic services (i.e., Speech therapy, occupational therapy, physical therapy, behavioral therapy, previous psychologist, etc.)? _____

_____

Does/did your child attend a preschool/VPK program? _____

_____

Does/did your child have an Individualized Education Plan (IEP)? If so under what category of eligibility (i.e., Developmental Delay, Specific Learning Disability, Autism, etc)? _____

Does/did your child experienced any challenges related to reading, math or writing?

_____

_____

Does your child have any behavioral concerns in his current classroom? _____

_____

_____

Are there any concerns with your child's current school/classroom placement? _____

_____

Behavioral History

Please check the areas of concern that apply to your child:

☐	Short attention span	☐	Peer Problems	☐	Food refusal / selectivity
☐	Distractible	☐	Limited imitation skills	☐	Eats non-food items
☐	Hyperactive	☐	Prefers to play alone	☐	Sleep Problems
☐	Impulsive	☐	Poor Eye Contact	☐	Mouths objects
☐	Aggressive	☐	Strong Interests/fixations	☐	Tooth grinding
☐	Destructive	☐	Repetitive Behaviors	☐	Sensory sensitivities
☐	Self-Injury (e.g. head banging)	☐	Ritualistic	☐	Visual inspect/stimulation
☐	Oppositional/Defiant	☐	Need for Routine	☐	High Pain Level
☐	Temper Tantrums	☐	Rocking/Self Stimulation	☐	Fearless
☐	Lying	☐	Flaps hands or flicks fingers	☐	Odd fears
☐	Stealing	☐	Peculiar Habits	☐	Social Anxiety
☐	Cruel to animals	☐	Toe Walking	☐	Stranger Anxiety
☐	Fire Setting	☐	Excessive Crying	☐	Separation Anxiety
☐	Sexualized Behaviors	☐	Excessive Laughing	☐	

What activities/toys does your child enjoy the most? _____

_____

_____

What activities/tasks are the most difficult for your child? _____

_____

_____

How does your child get along with his/her sibling(s)? _____

_____

_____

How does your child respond in the presence of other children? _____

_____

_____

Does your child prefer to play with younger, older, or same-aged peers? _____

_____

_____

What time of day is your child at his/her best? _____

_____

Do you have any concerns regarding your child's emotional state? _____

_____

_____

_____

Does your child have emotional reactions that are out of proportion for the events at hand? _____

_____

_____

Has your child been exposed to any form of abuse, neglect or domestic violence? ____

_____

_____

Please submit copies of any of the following if applicable:

1. Previous psychological/psychoeducational testing
2. Most recent Individualized Education Plan (IEP)
3. Behavior Intervention Plan (BIP)
4. Relevant Medical Records
5. Treatment Records