

CHILD & ADOLESCENT INTAKE SURVEY
CONFIDENTIAL

Affiliated Psychological & Medical Consultants
200 W. Academy Street, NW, Suite A
Gainesville, GA 30501-8524
Telephone 770-535-1284
FAX 770-536-3888

Please complete the following questions. Your thoughtful completion of these items will be most helpful.

Child's Name _____ Birthdate _____
Grade _____ Age _____ Sex _____ School _____

Who has legal custody of the child?

- _____ Mother & father married to each other and have custody
- _____ Mother has custody
- _____ Father has custody
- _____ Joint custody
- _____ Foster Care
- _____ Other

Child's Physician/Pediatrician _____
Telephone number _____

Referred here by: _____

Mother's Name: _____ Age ____ Education Level _____
Occupation _____ Telephone numbers: Home _____
Work _____ Cell Phone _____ Other _____

Father's Name: _____ Age ____ Education Level _____
Occupation _____ Telephone numbers: Home _____
Work _____ Cell Phone _____ Other _____

Stepmother's Name (If applicable) _____ Age _____
Education Level _____ Occupation _____

Stepfather's Name (If applicable) _____ Age _____
Education Level _____ Occupation _____

Briefly summarize the problems that bring you and your child here today:

How long has this been a problem? _____

What helps the problem improve? _____

What causes it to get worse? _____

List all people living in the household:

| Name | Relationship to Child | Age |
|-------|-----------------------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

If any brothers, sisters or other significant people are living OUTSIDE the home, list their names, ages and relationship to the child: _____

What issues does the family have that are important regarding your child? (Separation, family conflict, visitation, divorce or abuse issues, etc.) _____

MEDICAL HISTORY

Has your child ever suffered from:

High fevers ___ Yes ___ No If yes, please describe _____

Any chronic or serious illnesses (asthma, diabetes, epilepsy, etc.)? ___ Yes ___ No If yes, what illnesses: _____

Any Surgeries? ___ Yes ___ No If yes, please describe _____

Serious accident? ___ Yes ___ No If yes, please describe _____

Is your child on medication? ___ Yes ___ No If so, what medication and for what reason? _____

Does your child have any allergies? ___ Yes ___ No If so, what type? _____

DEVELOPMENTAL HISTORY

Were there any problems during pregnancy? Yes No If yes, explain: _____
 _____ Age of mother at time of birth _____

During pregnancy, did the mother:

Smoke? Yes No If so, how many cigarettes a day? _____

Drink alcoholic beverages? Yes No If yes, about how much each day? _____

Use drugs (including prescribed, over-the-counter and recreational)? Yes No If yes, what kind and how often? _____

Type of delivery? _____ Child's Birth Weight _____

Was the child premature: Yes No If yes, how many weeks? _____

Were there any complications during delivery? Yes No If yes, please describe what they were: _____

Was there anything unusual about your child's development (walking, talking, toilet training, sleeping, feeding, etc.) during the first few years? Yes No

If so, please describe: _____

OTHER INFORMATION

Have any members of your child's family suffered from any of the following:

| | | |
|---|--|---|
| <input type="checkbox"/> Academic problems | <input type="checkbox"/> Other Emotional Problems | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Developmental Problems | <input type="checkbox"/> Bi-Polar (Manic depression) | <input type="checkbox"/> Drug Problems |
| <input type="checkbox"/> Suicide attempts | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Other Mental Illness |

If any of the above applies, please list which family member and briefly describe the problem:

Has your child ever received psychological testing, therapy or counseling? Yes No If yes, please explain the reason, when and from whom: _____

Has your child ever been in trouble with the law? Yes No If yes, please describe, briefly:

Have there been any family stresses that have occurred in the last 12 months? (moves, job or school changes, financial changes, divorce, separations, deaths or other losses) _____

DISCIPLINE ISSUES

What type of discipline do you usually use with your child? (Please check all that apply)

- Ignore the behavior
- Spank your child
- Tell child to sit in chair
- Don't use discipline at all
- Redirect child's interest
- Threaten your child
- Send child to his/her room
- Other techniques (describe) _____
- Scold your child
- Reason with child
- Take away privileges

Which type is most effective? _____

Which type is least effective? _____

Who usually administers the discipline? _____

MISCELLANEOUS INFORMATION

What does your child like to do most/least? _____

What chores does your child do around the house? _____

What are your child's strengths or assets? _____

Is there any other information that you think might help me in working with your child?

Please complete the attached Social and Behavioral Checklist by indicating all that apply to your child.

THANK YOU!