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Comprehensive Intake Questionnaire for Pre-School Evaluations

This questionnaire will help me best understand your child and his/her current difficulties. Please fill out this questionnaire to the best of your ability **before** your intake appointment and bring it with you. Read the questions carefully and answer them as fully as possible (use the reverse side of the paper if necessary). If there are questions that you don't understand, please mark them with a star (*) and Dr. Aviv will review them with you at the intake appointment.

Date: _____

Name of child: _____ **Date of Birth:** _____ **Age**:_____

Name of person filling out form and relationship:_____

Home address and phone numbers of parents_____
Mother: _____ (H) _____(W) _____(C)
Father: _____ (H) _____(W) _____(C)

Family Email(s) _____

Child's Pre-School: _____

Current psychiatric diagnoses _____
Who diagnosed_____
Known genetic disorders or medical diagnoses:_____

Is your child taking any medications at this time? If yes, list all medications and current dosages and length of time your child has been on the medication.

Name of Current Medication(s)	Dosage	Since (date)

What problems or questions have caused you to seek help for your child at this time?

Family History

1. **Child is living with**:
   _____ Both parents
   _____ Mother
   _____ Father
   _____ Legal Guardian
   _____ Other (specify) _____

2. **Status of parent's marriage**:
   _____ Married (How long? _____ years)
   _____ Separated (Child's age at separation _____years)
   _____ Divorced (Child's age at divorce _____ years)
   _____ Single
   _____ Widowed

3. **If parents are divorced, please indicate whether there are step-parents**:
   _____ Stepmother
   _____ Stepfather

4. **Is your child adopted?**
   _____ Yes (If yes, age at adoption _____)
   _____ No

5. **Please complete the following information regarding biological parents in the appropriate column:**

	Mother	**Father**
Age		
Highest Level of Education Completed		
Degrees/Diplomas		
Current Occupation		
Describe any special education or tutoring received		
Describe grades repeated or subject areas that were difficult		
Any diagnosed learning difficulties? If so in what subjects?		
Any psychological or psychiatric problem for which treatment was received?		
Any Attention Deficit Disorder (with or without Hyperactivity?)		

6. **If any of the following parental relationships are relevant, please circle relevant relationship and complete:**

	Adoptive Mother/Stepmother	Adoptive Father/Stepfather
Age		
Highest Grade Completed		
Occupation		

7. **Other children in the family (including step-siblings and half-siblings)**

Name	Gender	Age	In home?	Social/Behavioral/Health problems? List

8. **Biological extended family**

Do any extended family (maternal/paternal grandparents, uncles, aunts, cousins) suffer from any of the following: inattentiveness or hyperactivity; behavior problems; learning difficulties; epilepsy; seizures; migraines; alcoholism/drug abuse; psychological, emotional or personality difficulties; depression or bipolar disorder; schizophrenia; developmental disabilities; Autism or Aspergers disorder; Anxiety or "nervousness"; congenital abnormalities ; other neurological conditions etc.? If so, please list the relationship to your child, the disorder and any treatment received:

Maternal (mother's side) **Paternal (father's side)**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please provide any additional information about your child's extended family that might help me understand your child's needs (medical, behavioral, psychological, educational, and emotional):

_____
_____
_____

9. **Pregnancy with this child**:

Length of pregnancy _____ weeks

Any of the following complications during pregnancy with this child (check all that apply):

_____Difficulty in Conception
_____Abnormal Weight Gain
_____Excessive Vomiting
_____Excessive Swelling
_____Vaginal Bleeding
_____Anemia
_____Other (e.g. Rh incompatibility)
_____Toxemia
_____Measles
_____German Measles
_____Emotional Problems
_____Flu
_____High Blood Pressure
_____Maternal Injury
_____Hospitalization during pregnancy (what month_____)
_____X-Rays during pregnancy (what month? _____)
_____Medication during pregnancy (what?_____)
_____Alcohol during pregnancy (frequency_____)
_____Cigarettes during pregnancy (frequency_____)
_____Other drugs during pregnancy (Type and frequency_____)
_____ Drugs while trying to conceive (mother)
_____ Drugs while trying to conceive (father)

10. Birth:

Mother's age at birth of child _____ years
Father's age at birth of child _____years
Was child born in a hospital? ____Yes _____No
Length of Labor: _____ hours
Child's Birth Weight: _____lbs. _____ozs.
Apgar Scores: _____
Child's condition at birth _____

Check the relevant birth details:

____ Vaginal delivery ____ Caesarean Section
____ Forceps used
____ Breech Birth
____ Induced Labor
____ Delivery complications (describe _____)
____ Incubator needed
____ Jaundiced (If yes, Bilirubin lights? _____Yes _____No)
____ Breathing problems right after birth (describe_____)
____ Supplemental oxygen (how long needed_____)
____ Birth defects (explain_____)
____ NICU stay (details_____)

11. Do you think this child's difficulties might be related to pregnancy, labor or delivery?

_____Yes (Details_____)
_____No

12. Did this child have frequent ear infections as an infant? _____Yes _____ No
If yes, did this child have ear tubes inserted surgically ? _____ Yes _____No

13. Gross Motor, fine motor, and Language milestones: At what age did this child first do the following (in months)?

_____ Turned Over

_____ Sat Alone

_____ Crawled

_____ Stood Alone

_____ Walked Alone

_____ Fed self with spoon

_____ Scribbled

_____ Understood first words

_____ Spoke first words

_____ Spoke in sentences

14. Can you child do any of the following (circle all that apply):

a. Ride a bike
b. Throw and/or catch a ball
c. Skip, hop, jump

15. Has this child ever received Occupational Therapy
_____Yes (Details_____) _____No

16. Has this child ever received Physical Therapy
_____Yes (Details_____) _____No

17. At what age did this child toilet train?
_____ days _____ nights

18. Did bed-wetting and/or bed soiling occur after training?
_____Yes (until what age_____) _____ No

19. Has this child every received speech and/or language therapy?
_____Yes (Details_____) _____No

20. Is your child left or right handed? _____

21. Infancy and Early childhood: Please rate this child on the following behaviors. Check 1 if the behavior on the left was present the majority of the time and check 5 if the behavior on the right was present the majority on the time. Stages in between are represented by 2, 3, and 4.

Quiet and content	1	2	3	4	5	Colicky and irritable
Very easy to feed	1	2	3	4	5	Daily feeding problems
Slept well	1	2	3	4	5	Daily/frequent sleeping problems
Usually relaxed	1	2	3	4	5	Often restless
Underactive	1	2	3	4	5	Overactive
Cuddly, easy to hold	1	2	3	4	5	Did not enjoy cuddling
Easily calmed down	1	2	3	4	5	Tantrums and/or head banging
Cautious and careful	1	2	3	4	5	Accident prone and/or daredevil
Coordinated	1	2	3	4	5	Uncoordinated
Enjoyed eye contact	1	2	3	4	5	Avoided eye contact
Liked People	1	2	3	4	5	Disliked contact with people

22. Other comments/problems regarding infancy or early childhood development:

23. Did any event, health condition, separation etc. disturb infant/parent bonding or the developing toddler/parent relationship?

_____Yes (Details_____)

_____No

24. Who is your child's pediatrician? (No information will be released or obtained without your written permission)

Name_____ Office Phone Number_____

25. Has your child ever had a psychiatric or neurological examination?

_____Yes (Details_____) _____No

26. If your child is currently under psychiatric or neurological care, please give the name, address and phone number of the treating physician. (No information will be released or obtained without your written permission)

Name_____ Office Phone Number_____

27. Does your child wear a hearing aid? _____Yes _____No

28. Does your child wear glasses/contact lenses? _____Yes _____No

29. Medical History: Please indicate whether your child has had any of the following significant illnesses/conditions:

Condition	Yes	No	Comments (include meds.)
Measles			
German Measles			
Mumps			
Chicken Pox			
Tuberculosis			
Rheumatic Fever			
Diphtheria			
Meningitis			
Encephalitis			
Whooping Cough			
Scarlet Fever			
Head Injury			
Coma or loss of consciousness			
Sustained high fever			
Any fever above 104 degrees			
Anemia			
Broken bones			
Asthma			
Sinus condition			
Surgery 1. 2. 3.			
Allergies to food			
Allergies to medicine			
Environmental allergies			
Respiratory Conditions			
Frequent Colds			
Chronic Cough			
Asthma			
Hay Fever			
Sinus Condition			
Cardiovascular Conditions			
Shortness of breath with exertion			
Dizziness with exertion			
Heart condition			
Heart Murmur			

30. Please indicate whether your child currently has or has had any of the following health concerns:

Gastrointestinal Conditions	**Yes**	**No**	**Comments (include meds.)**
Excessive Vomiting			
Frequent Diarrhea			
Constipation			
Stomach Pain			
Genitourinary Concerns			
Urination in pants/bed			
Pain while urination			
Excessive urination			
Strong odor to urine			
Musculoskeletal Concerns			
Muscle Pain			
Clumsy Walk			
Poor posture			
Other muscle problems			
Skin Concerns			
Frequent rashes			
Bruises easily			
Sores			
Severe Acne			
Eczema			
Neurological Concerns			
Seizures/convulsions			
Speech defects			
Accident prone			
Sucks thumb			
Grinds teeth			
Bites nails			
Picks skin			
Tics/Twitches			
Bangs head			
Rocks back and forth			
Unusual body movements			
Speech Concerns			
Stuttering			
Unclear speech			
Other speech problems			

31. Please list any medication taken by your child in the past for longer than 3 months duration that he/she is no longer taking.

Name of Previous Medication(s)	Dosage	From (date)	Until (date)

32. Which of the following best describes the way your child is related to by other children?

a. My child is very popular with his/her peers.
b. My child is neither popular or unpopular with his/her peers.
c. My child is unpopular with his/her peers.

33. Which best describes the role your child takes with peer interactions:

a. My child likes to be the leader most of the time.
b. My child prefers follow other kids.
c. My child can flexibly take the role of either the leader or the follower depending on the situation.

34. The following table is designed to assess your child's ability to relate to other children.

	Yes	No
Does your child have difficulty relating to other children?		
Does your child physically fight a lot with other children?		
Does your child argue a lot with other children?		
Does your child prefer playing with younger children?		
Does your child have difficulty making friends?		
Does your child have difficulty maintaining friendships?		
Does your child have a best friend?		
Is your child invited to other children's houses for play dates?		
Is your child invited to birthday parties as often as you think he/she should be?		
Are there children in your neighborhood with whom your child can play?		
Does your child prefer to play alone?		
Does your child have difficulty with the non-verbal rules of social interaction (e.g. turn taking, how close to stand to others)		

35. Any other comments about your child's interactions with other children?

36. Is your child enrolled in any extracurricular activities or hobbies (e.g. team or individual sports, music lessons, karate, boy/girl scouts, etc…. Please list:

_____
_____
_____
_____
_____

37. What time does your child go to bed?_____

38. What time does your child get up? _____

39. Does your child nap during the day? ____ Yes ____No **If so for how long** ____

40. Does your child have a consistent bedtime routine?

_____ Yes _____ No

41. Are you concerned that your child does not get enough sleep and/or has poor sleep quality?

_____ Yes _____ No

42. Educational History. Please identify all preschools/daycares and schools your child has attended giving dates of attendance in sequential order.

Name of Preschool/Daycare/School	From (date)	To (date)	# Days/week	# Hours/day

43. Describe what you hear from your child's teachers about your child's experience at pre-school.

44. Is your child currently receiving any special education services?

_____ Yes (**If yes, please bring copies of IEP or 504 plan**) _____ No

45. Please complete the following table regarding your child:

	Yes	No	Not Sure
Sensory Domain			
Is your child bothered by getting messy?			
Is your child bothered by clothing textures or clothing tags?			
Is your child bothered by loud or unexpected sounds?			
Does your child eat a wide variety of foods?			
Do any smells bother your child?			
Is your child overly active?			
Fine Motor			
Does your child stack blocks?			
Does your child scribble on a picture?			
Does your child copy vertical and horizontal lines?			
Does your child snip paper with scissors?			
Can your child unscrew the lid of a jar?			
Can your child work a puzzle?			
Self-help			
Does your child drink from an open cup?			
Does your child use a spoon at meals?			
Can your child undress self?			
Can your child put on clothes?			
Can your child put on shoes/socks?			
Can your child opens/close zippers?			
Can your child opens/close buttons?			
Can your child 0pens/closes velcro fasteners?			
Can your child wash own hands with soap?			
Can your child pull pants up/down for toileting?			
Eating Habits			
Can your child feeds him/her self with utensils?			
Does your child eat a variety of foods?			
Can your child sit down at meal times?			
Can your child drink from a cup without spilling?			
Can your child get a snack be him/her self?			
Can your child			
Gross Motor			
Can your child jump forward with both feet?			
Can your child kick a ball?			
Can your child walk up and down stairs with a handrail?			
Can your child walk across a low balance beam?			
Can your child pedal a tricycle?			
Can your child run without difficulty?			
Can your child safely access outdoor playground equipment?			

Observations at Play

46. How does your child learn a new activity Does he/she learn by watching you or does he/she need your physical assistance?

47. After learning an activity, does he/she need help to remember how to do it?
____Yes ____No ____Not Sure

48. Does your child use primarily one hand when eating, coloring, and throwing, or do they switch hands frequently?

49. How long does your child sit and play?

50. What toys does your child like to play with?

51. What are some of your child's favorite activities?

52. Does your child transition from one activity to another with ease?

53. Describe your child's daily schedule

54. Please circle the traits/characteristics below which apply to your child now:

Happy	Sad	Moody
Friendly	Quiet	Overactive
Independent	Dependant	Sensitive
Affectionate	Fearful	Overreacts when faced with a problem
Tantrums	Lethargic	Requires a lot of parental attention
Too responsible	Even tempered	Short attention span
Impulsive	Angry	Lacking in self control
Explosive	Volatile	Withholding of affection
Thoughtful	Dreamer	Difficulty calming down
Cooperative	Withdrawn	Easily over-stimulated

55. Other words <u>you</u> would use to describe your child:

56. Please describe any major family or parental stressors that may have impacted your child in the past or that may impact him or her now:

57. Are there any particularly traumatic or troubling events which have happened in this child's life which I should know about in order to understand him/her better? (please give details, include incidents you feel were traumatic for this particular child, though they might not have been for another child)

58. Has your child ever witnessed violence inside or outside of the home?
____ Yes, If Yes, please give details below: ____ No

59. Has your child ever had psychological counseling or therapy?
____ Yes, If Yes, please give details below: ____ No

Therapist Name	**Address**	**Phone Number**	**Dates of treatment**

60. Please list the names, addresses, and telephone numbers of any other professionals consulted. (This does not give me permission to contact them, and they will only be contacted with your written consent.)

61. Is there any additional information or anything that you feel is pertinent to know regarding your child that has not been covered in this questionnaire?

62. What changes do you hope will result from seeking comprehensive psychological evaluation services?

63. Who referred you to Dr. Aviv's clinic?