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Comprehensive Intake Questionnaire for Re-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.

Child/Adolescent/dependant's information

Date: _____

Name of child/adolescent: _____

Date of Birth: _____ **Age**:_____

Name of person filling out form and relationship: _____
_____

Home address: _____

Telephone Numbers of parent(s):

Mother: _____ (H) _____(W) _____(C)
Father: _____ (H) _____(W) _____(C)

Family Email(s) _____

School attended last year: _____
School plan for next year:_____
Current Grade placement: _____

Current Learning and/or Psychiatric diagnoses _____

1. **What are your main concerns about your child at this time?**

2. **Complete the table for all interventions your child received since his/her last evaluation in this clinic. Please add any additional interventions as "Other". Use other side if needed**

Intervention	Provider	Beginning and Ending Dates Intervention received	Frequency e.g. once/week
Tutoring: Reading			
Tutoring: Math			
Tutoring: Writing			
Tutoring: Other			
Psychiatric medications			
Individual Psychotherapy			
Family Therapy			
Change of School			
School Accommodations			
Sleep Study			
Language evaluation and/or treatment			
Other			

Family History

3. **Has there been a change in parent's marital status since your child's last evaluation?**
   _____ Yes (If yes, describe_____)
   _____ No

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

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

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

Condition	Yes	No
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		
Condition	**Yes**	**No**

Sinus condition		
Surgery 1. 2. 3.		
Allergies to food		
Allergies to medicine		
Environmental allergies		

6. Please indicate whether your child has or has had any of the following health Concerns since the last evaluation:

Respiratory Conditions	Yes	No	Comments (include meds.)
Frequent Colds			
Chronic Cough			
Asthma			
Hay Fever			
Sinus Condition			
Cardiovascular Conditions			
Shortness of breath with exertion			
Dizziness with exertion			
Heart condition			
Heart Murmur			
Gastrointestinal Conditions			
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	Yes	No	Comments (include meds.)
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			
Hearing Concerns			
Hearing aid			
Vision Concerns			
Glasses or contact lenses			

7. **Are you concerned that your child does not get enough sleep and/or has poor sleep quality?** _____ Yes _____ No

   If yes, explain:

   _____
   _____
   _____

8. **Who is your child's current pediatrician/doctor?** (No information will be released or obtained without your written permission)

   Name_____ Office Phone Number_____

9. **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)

10. How has your child been doing in school since the last evaluation? (Bring school reports and standardized tests.)

_____
_____
_____
_____
_____
_____
_____
_____

11. Has your child repeated a grade since the last evaluation?

_____ Yes _____ No

12. **Has your child skipped a grade since the last evaluation?**

_____ Yes _____ No

13. Does your child like going to school?

_____ Yes _____ No

14. Do you have concerns about the quality of your child's school and/or teachers?

_____ Yes _____ No

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

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

16. Has your child taken any standardized achievement tests at school (MAP/ERB/SAT/ACT etc.)?

_____ Yes (**If yes, please bring copies of results**) _____ No

17. **Which of the following best describes the way your child is currently related to by peers?**
    a. My child is very popular with his/her peers.
    b. My child is neither popular nor unpopular with his/her peers.
    c. My child is unpopular with his/her peers.

18. Which best describes the role your child currently 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.

19. 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 teens?		
Does your child physically fight a lot with other teens?		
Does your child verbally argue a lot with other teens?		
Does your child prefer being with younger kids?		
Does your child have difficulty making friends?		
Does your child have difficulty maintaining friendships?		
Does your child have at least one good friend?		
Is your child invited to friend's houses?		
Does your child like to host others at your house?		
Does your child have a small group of good friends?		
Does your child prefer to be alone?		
Does your child have difficulty with the non-verbal rules of social interaction (e.g. turn taking, how close to stand to others)		
Do you mostly like your child's choice of friends?		

20. Any other comments about your child's interactions with others?

_____
_____
_____

21. 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:

_____
_____
_____

22. Do you have concerns or evidence that your child uses drugs and/or drinks alcohol?

_____ Yes _____ No

If Yes, Explain_____

23. Describe your child's use of screens (TV; Gaming consoles; Computers)

____ Less than 1 hr/day
____ 1-2 hrs/day
____ 2-4 hrs/day
____ more than 4 hrs/day

24. Does your child have a cell phone?

_____ Yes _____ No

25. Does your child have social networking access (e.g. facebook)

_____ Yes _____ No

26. 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

Other words you would use to describe your child:

_____
_____
_____
_____

27. What changes do you hope will result from seeking comprehensive psychological re-evaluation services at this time?

_____
_____
_____
_____

28. Is there anything else that you want to mention or feel that it would be helpful for me to know about?

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Consent to Treatment Form

I, _____ am requesting psychological services for my child, _____(child's name). If my child is over 18, I acknowledge that they will be required to sign a separate consent to treatment form for evaluation to proceed.

I understand that these services will be rendered by Dr. Alyson Aviv, a licensed clinical psychologist. I consent to receive these services on behalf of my child.

I understand that all information is kept strictly confidential and cannot be released without my written permission. **I acknowledge that payment will be made by check at the time of service**. Should I fail to pay for services rendered; I understand that notification of a professional collection agency may be made concerning my outstanding debt.

I also acknowledge that I have been informed that I will be provided with the opportunity to receive a copy of Dr. Aviv's Notice of privacy practices at my appointment.

_____
Parent or legal guardian's signature

_____
Date