

Center for Integrative Therapy - Child/Teen Intake Questionnaires

Please fill it out to the best of your ability (To be filled out by parents). Don't worry if there is information that you don't remember or seems too complex to write down.

Primary care physician: _____

Main Purpose of the consultation (please give brief summary of the main problems):

Medical History

Current medical problems: _____

Past Medical problems: _____

Medications: _____

Vitamins or supplements: _____

Surgeries: _____

Any history of hospitalization?(if yes, when?) _____

Any history of abnormal lab test, X ray, EEG etc.? _____

Any history of head trauma?(describe) _____

Allergies to drug and other substances: _____

Current stressors for whole family: _____

Family History

Family structure(who lives in the current household with the child, please mention the relationship to the child) _____

Family Development(include marriages, separations, divorces, deaths, traumatic events, losses, etc.): _____

Mother's history: age _____ Occupation _____

Education (highest level completed): _____

Learning problems(specify) _____

Behavior problems (specify) _____

Medical problems _____

Father's history: age _____ Occupation _____

Education (highest level completed): _____

Learning problems(specify) _____

Behavior problems (specify) _____

Medical problems _____

Siblings(names, ages, problems, strengths, relationship with the patient): _____

CHILD'S DEVELOPMENTAL HISTORY

Prenatal events:

Pregnancy complications(excessive vomiting, bleeding, infection, medication, alcohol/drug use, smoking) etc.

Birth and post natal period:

Birth weight____ Length____ Labor duration____ Delivery: Vaginal____ C section Problems____
APGAR score(if known)____ Any jaundice? Yes____ No____ Time in hospital____
Complications?_____

Feeding history: breast Vs bottle _____ Age weaned _____ Food allergies _____
infant feeding problems_____

Sleep behavior: (nightmares, sleepwalking, recurrent dreams, current problem with going to bed and getting up)_____

History of Physical/sexual abuse:_____

Motor Development: (please write the age, parentheses are approximate normal limits)

rolls over(3-5m)____ Sits without support(5-7m)____ crawls(5-8m)____ Walks well(11-16m)____
runs well(2y)____ rides tricycle(3y)____ throws ball over hand(4y)____ Current level of
activity_____ fine and gross motor coordination compared to peers_____

Language Development: (please write the age, parentheses are approximate normal limits)

several words besides mama, dada(1y)____ name several objects; dog,ball,cup(15m)____
3 words together; subject,verb and object(2y)____ vocabulary____ articulation____
comprehension____ compared to peers____
any current problems_____

Social development: (please write the age, parentheses are approximate normal limits)

smile(2m)____ shy with strangers(6-10 m)____ separates from mother easily (2-3 y)____
cooperative play with others(4 y)____ quality of attachment to mother____
quality of attachment to father____ relationships to family member____
____ early peer interactions____
current peer interactions____
special interest/hobbies_____

Behavior/Discipline: compliance vs noncompliance _____
rule breaking _____ lying/stealing _____ methods of discipline _____
_____ other issues _____

Emotional Development: early temperament _____
current personality _____
mood _____ fears/phobias _____
habits _____
ability to express feelings _____

Drug/Alcohol History: _____

School History: Current grade _____ school contact _____
number of schools attended _____ average grades _____
homework problems _____
specific learning disabilities _____
strengths _____
teacher's comment about the child/teen _____

Overall strength as viewed by parents _____

Overall strength as viewed by the child/teen _____

Thank you for taking time to complete this form. This information will be very helpful in your child's health assessment and treatment.

We look forward to your visit and help your child in healing and wellness.