DIAGNOSTIC INTAKE FORM

CHILD'S NAME:

____

CHILD'S DATE OF BIRTH:

____

PLEASE STATE THE REASON FOR YOUR VISIT

____

____

____

____

____

WHAT ARE THE TOP THREE CONCERNS FOR YOUR CHILD:

1.____

2.____

3.____

WHO REFERRED YOU TO TREEHOUSE PSYCHOLOGY, PLLC?

____

PLEASE LIST DIAGNOSES YOUR CHILD HAS CURRENTLY:

____

PLEASE LIST CURRENT MEDICATIONS:____

CHILD'S DOCTOR: ____

ARE THERE ANY DIAGNOSES YOU ARE WORRIED ABOUT FOR YOUR CHILD?

____

SOCIAL HISTORY

DOES YOUR CHILD LIVE: HOME APARTMENT W/FAMILY HOMELESS
TOWNHOUSE SHELTER

PARENTS ARE: MARRIED NEVER MARRIED SEPARATED DIVORCED
IN RELATIONSHIP MARRIED

LIVING IN YOUR HOUSE:
(list age and gender)

SIBLINGS (FULL):________________________________
SIBLINGS (HALF):________________________________
FATHER________________________________
MOTHER________________________________
STEPFATHER________________________________
STEPMOTHER________________________________
ADOPTED MOTHER________________________________
ADOPTED FATHER________________________________
STEP-SIBLINGS________________________________
ADOPTED SIBLINGS________________________________

HAS CHILD PROTECTION BEEN INVOLVED IN YOUR FAMILY? Y N
HAS YOUR CHILD HAD FOSTER PLACEMENT? Y N

FAMILY HISTORY

	MOM SIDE	DAD SIDE
ALCOHOLISM		
ADHD		
LEARNING DISABILITY		
DEPRESSION		
ANXIETY		
SUICIDE		
DRUG OR ALCOHOL PROBLEMS		
PRISION/JAIL		
OCD		
TRAUMA		
AUTISM		
MENTAL RETARDATION		
BIPOLAR		
OTHER:		

WHO DOES MOST OF THE PARENTING IN THE HOME? (Circle)

MOM DAD STEPDAD STEPMOM OLDER SIB GRANDPARENT PARTNER

DOES DAD WORK?	Y	N	PART TIME	FULL TIME
DOES MOM WORK?	Y	N	PART TIME	FULL TIME
CHILD HAS A PCA?	Y	N	PART TIME	FULL TIME
CHILD HAS NANNY	Y	N	PART TIME	FULL TIME

WHERE IS YOUR CHILD DURING THE DAY? ____

CHECK or CIRCLE ANY OF THE FOLLOWING EVENTS EXPERIENCED BY YOUR CHILD AND WHEN:

FIRE OR FLOOD IN HOME
LOSS OF RELATIVE
LOSS OF PET
DIVORCE
PARENT SEPARATION
PLACEMENT IN FOSTER CARE
ADOPTION
PHYSICAL ABUSE
TRAUMATIC INJURY OR HEAD INJURY/
CONCUSSION
PSYCHIATRIC HOSPITALIZATION

SEXUAL ABUSE
EXPOSURE TO MARITAL CONFLICT
DRUG OR ALCOHOL OVERDOSE
EXPOSURE TO DOMESTIC ABUSE
PARENT INCARCERATION
DEATH OF PARENT
FINANCIAL DIFFICULTIES IN FAMILY
MILITARY DEPLOYMENT/SEPARATION
DRUG OR ALCOHOL ABUSE IN PARENT
CHILD PROTECTION INVOLVEMENT
LEGAL DIFFICULTIES

BIRTH AND EARLY DEVELOPMENT

WAS YOUR CHILD BORN ON TIME?	Y	N
PREMATURE?	Y	N
HEALTHY BIRTH WEIGHT?	Y	N
HAVE JAUNDICE?	Y	N
BORN TESTING POSITIVE TO DRUGS?	Y	N
C-SECTION?	Y	N
PROBLEMS WITH BIRTH FOR YOUR CHILD?	Y	N
WAS YOUR CHILD IN THE NICU?	Y	N
DID YOU BREAST FEED?	Y	N
DID YOUR CHILD HAVE SLEEP PROBLEMS?	Y	N
DID YOUR CHILD HAVE MEDICAL ISSUES?	Y	N

WAS YOUR CHILD EXPOSED DURING PREGNANCY TO:

ALCOHOL
Y N

TOBACCO
Y N

MARIJUANA
Y N

HEROIN
Y N

METHAMPHETAMINE
Y N

COCAINE/CRACK
Y N

PRESCRIBED DRUGS
Y N

OTHER:
Y N

DEVELOPMENTAL ISSUES

DID YOUR CHILD CRAWL ON TIME?	Y	N	
WALK ON TIME?	Y	N	
SPEAK FIRST WORDS BY 1	Y	N	
SPEAK FIRST WORDS BY 2	Y	N	
USE SENTENCES BY AGE 2	Y	N	
USE SENTENCES BY AGE 3	Y	N	
EXPLORE HIS ENVIRONMENT	Y	N	
ATTEND SCHOOL ON TIME	Y	N	
DID YOUR CHILD EVER HAVE EAR INFECTIONS?	Y	N	
DID YOUR CHILD NEED GLASSES AT ANY TIME?	Y	N	
DID YOUR CHILD HAVE ADEQUATE HEARING?	Y	N	
DID YOUR CHILD HAVE A HEAD INJURY EVER?	Y	N	
DID YOUR CHILD EVER SUSTAIN A MAJOR INJURY?	Y	N	
HAS YOUR CHILD BEEN HOSPITALIZED?	Y	N	
HAS YOUR CHILD HAD ALLERGIES?	Y	N	
HAS YOUR CHILD HAD SEIZURES?	Y	N	
HAS YOUR CHILD HAD SURGERIES?	Y	N	LIST: ____________________

SCHOOLING:

CHILD'S SCHOOL: ____

GRADE: ___________

RECEIVES SPECIAL EDUCATION SERVICES:	Y	N
REPEATED GRADES	Y	N
IS GIFTED	Y	N
HAS LOW IQ OR IS INTELLECTUALLY DISABLED	Y	N
HAS DEVELOPMENTAL DELAYS	Y	N
RECEIVES IN SCHOOL SPEECH	Y	N
RECEIVES IN SCHOOL PT OR OT (CIRCLE)	Y	N
SEES A COUNSELOR AT SCHOOL	Y	N
HAS A TUTOR	Y	N
IN FEDERAL LEVEL 4 PROGRAM	Y	N

NOTES:

PROBLEM BEHAVIORS AND CONCERNS

CHECK ALL THAT APPLY:

HISTORY OF ABUSE PRIOR TO ADOPTION
NEGLECT DURING CHILDHOOD
ABUSE DURING CHILDHOOD
MALTREATMENT DURING CHILDHOOD
LEARNING DISABILITIES
ADHD
IMPULSIVENESS
STEALING
LYING
PHYSICAL AGGRESSION TOWARD OTHERS (E.G., HITTING)
RUNNING AWAY
USING DRUGS OR ALCOHOL
WORRY ABOUT EVERY DAY LIFE ISSUES
PHOBIAS
GETS STUCK DURING TRANSITIONS
OBSESSIONS
COMPULSIVE BEHAVIORS
HEARS THINGS THAT ARE NOT THERE
SEES THINGS THAT ARE NOT THERE
TALKS TO SELF
SUCKS THUMB
GRINDS TEETH
SEXUAL PROBLEMS
SLEEP ISSUES
EXCESSIVE CRYING
SEEMS IN A FOG
SEEMS CONFUSED OFTEN
HAS POOR SAFETY BEHAVIORS (RUNS INTO STREET)
OVERLY FRIENDLY
HURTS SELF IN SOME WAY
THREATENS TO KILLS SELF
PREFERS TO BE ALONE
LINES UP OBJECTS OR SEEMS PREOCCUPIED WIHT PARTS OF THINGS

ROCKING BEHAVIORS
SPINNING BEHAVIORS
ODD HAND MANNERISMS
TICS
CLUMSY AND AWKWARD
AVOIDS TOUCH
OVERLY SENSITIVE HEARING
OVERLY SENSITIVE TO LIGHTS
ENGAGES IN SELF-STIMULATORY BEHAVIORS
POOR EYE CONTACT
FEW OR NO FRIENDS
POOR COOPERATION
FIGHTS WITH OTHERS
POOR HYGIENE
RUNNING OR MOVING EXCESSIVELY
FIDGETING AND RESTLESS
WORRIES ABOUT BAD THINGS HAPPENING

PARENTING

CHECK TYPES OF DISCIPLINE USED:
TIME OUT
YELLING
GIVING CHORES
IGNORING
WALK AWAY OR LEAVE
TAKE AWAY TOYS
TAKE AWAY DEVICES
TAKE AWAY PRIVILEGES
REMOVE FOOD
EARLY BEDTIME
SPANKING
OTHER TYPE OF PUNISHMENT
REWARDS

HOW DO YOU DESCRIBE YOURSELF AS A PARENT?

____
____
____
____
____
____
____
____

TREATMENT HISTORY:

INDIVIDUAL THERAPY IN PAST?	Y	N
MENTAL HEALTH EVALUATION?	Y	N
FAMILY THERAPY?	Y	N
IN-HOME THERAPY?	Y	N
RECEIVES CASE MANAGEMENT SERVICES?	Y	N
CHILD SEEN A MENTAL HEALTH PRACTITIONER IN THE PAST YEAR?	Y	N
TOOK MEDICATIONS IN THE PAST?	Y	N

WHAT SERVICES ARE YOU INTERESTED IN FOR YOUR CHILD AND FAMILY? (CHECK)
THERAPY FOR MY CHILD
PARENTING SUPPORT OR THERAPY FOR PARENT
FAMILY THERAPY
PSYCHOLOGICAL TESTING
NEUROPSYCHOLOGICAL TESTING
MEDICATION
PLAY THERAPY
AUTISM EVALUATION
ADHD TESTING
LEARNING EVALUATION
SIBLING THERAPY
LGBTQ COUNSELING
PSYCHOSEXUAL EVALUATION
COURT-ORDERED EVALUATION