SHORELINE PEDIATRIC NEUROPSYCHOLOGICAL SERVICES, L.L.C.
ASSESSMENT AND CONSULTATION SERVICES

SHELLEY F. PELLETIER, PH.D., NCSP, ABPP
LICENSED PSYCHOLOGIST
BOARD CERTIFIED IN SCHOOL PSYCHOLOGY
BOARD CERTIFIED IN CLINICAL NEUROPSYCHOLOGY
BOARD CERTIFIED SUBSPECIALIST IN PEDIATRIC NEUROPSYCHOLOGY

CHILD/ADOLESCENT INTAKE QUESTIONNAIRE

Identifying information

Child's full name _____ Name called _____

Person completing this form _____ Relationship to child _____

Birthdate ___/___/___ Gender ☐M / ☐F Handedness ☐R / ☐L Height ___ Weight ___Age ___

Ethnicity _____ Primary language _____ Other language(s) in the home _____

Home address _____

Home phone _____ Cell phone _____

Permission to leave messages: Home phone ☐ no / ☐ yes Cell phone ☐ no / ☐yes

Reason for referral

Who referred you for an evaluation? _____

What do you hope to gain from this evaluation? _____

_____

_____

Information requested on this questionnaire is an important part of this child's evaluation. I appreciate your filling it out as best you can. If you are unsure of how to respond to a question or if a question does not apply, you can skip it and move on to the next question.

Please feel free to add as much information as you want and use additional pages if necessary. The highest standards of professional confidentiality are maintained. Information about any particular individual can be released only with the explicit written consent of that person or his/her parent(s)/legal guardian except in exceptional legal circumstances.

Family Background

Does this child live with you? ☐ no / ☐ yes

If this child is a foster child, at what age was the child placed with you?_____

If this child had any foster placements prior to placement in your home, list the location and length of each placement _____

_____

If this child is an adopted child, at what age was the child placed with you? _____

At what age was the adoption finalized? _____

If this is a foster or adopted child, has the subject been discussed with the child? ☐ no / ☐ yes

Name(s) of current legal guardian(s) _____

Biological Parent (specify relationship) _____

Name _____

Address _____ Phone _____

Occupation _____ Highest educational level _____

Difficulties in learning ☐ no / ☐ yes Describe_____

Other disabilities / difficulties (e.g., physical, psychological, or educational) ☐ no / ☐ yes

Describe _____

Biological Parent (specify relationship) _____

Name _____

Address_____ Phone _____

Occupation _____ Highest educational level _____

Difficulties in learning ☐ no / ☐ yes Describe _____

Other disabilities / difficulties (e.g., physical, psychological, or educational) ☐ no / ☐ yes

Describe _____

*Step/Adoptive Parent (specify relationship)*_____

Name _____

Address_____ Phone _____

Occupation _____ Highest educational level _____

Difficulties in learning ☐ no / ☐ yes Describe _____

Other disabilities / significant difficulties (e.g., physical, psychological, or educational) ☐ no / ☐ yes

Describe _____

*Step/Adoptive Parent (specify relationship)*_____

Name _____

Address_____ Phone _____

Occupation _____ Highest educational level _____

Difficulties in learning ☐ no / ☐ yes Describe _____

Other disabilities / significant difficulties (e.g., physical, psychological, or educational) ☐ no / ☐ yes

Describe _____

Does this child have brothers or sisters? ☐ no / ☐ yes (Please list below / or on last page, if needed)

Gender	Age	Grade	Difficulties in learning or other disabilities (describe)

Family members with significant conditions:

If any members of this child's family has or had any of the following conditions, indicate the condition, the family member (e.g., father, maternal grandmother) who has or had it, and the nature and severity of the condition.

Mental health disorders ☐ no / ☐ yes who _____what_____
Mental retardation ☐ no / ☐ yes who _____what_____
Epilepsy ☐ no / ☐ yes who _____what_____
Serious chronic illness ☐ no / ☐ yes who _____what_____
Speech/language problems ☐ no / ☐ yes who _____what_____
Substance abuse ☐ no / ☐ yes who _____what_____
Trouble with the law ☐ no / ☐ yes who _____what_____

Nature/severity of condition(s) _____

_____

Birth History This section is to be completed by the caregiver most familiar with the child's birth history. If this child is an adopted/foster child, please complete according to your knowledge.

Regarding the pregnancy with this child:

Bleeding ☐ no / ☐ yes Specify _____
Illness ☐ no / ☐ yes Specify _____
Rh incompatibility ☐ no / ☐ yes Specify _____
Medications taken ☐ no / ☐ yes Specify _____

Describe any other unusual circumstances _____

Birth of this child:

Was delivery ☐ early how early?_____ ☐ on time ☐ late how late?_____

Labor False ☐ no / ☐ yes Induced ☐ no / ☐ yes Length _____
Anesthesia ☐ no / ☐ yes Natural ☐ no / ☐ yes Birthweight _____
Type of birth Normal ☐ no / ☐ yes Breech ☐ no / ☐ yes Forceps ☐ no / ☐ yes
Caesarean ☐ no / ☐ yes Apgar Score _____
Complications_____
Color Normal ☐ no / ☐ yes Blue ☐ no / ☐ yes Jaundiced ☐ no / ☐ yes

Transfusions ☐ no / ☐ yes Incubator required ☐ no / ☐ yes How long?_____

Breathing problems ☐ no / ☐ yes Oxygen required ☐ no / ☐ yes How long?_____

Difficulties sucking, swallowing, or feeding ☐ no / ☐ yes Specify_____

Describe any other unusual circumstances_____

_____

_____

Developmental History

Relative to expectations, when did this child:

Sit alone	☐ early	☐ on time	☐ late
Say his/her first word	☐ early	☐ on time	☐ late
Walk alone	☐ early	☐ on time	☐ late
Understand speech	☐ early	☐ on time	☐ late
Use 2-word sentences	☐ early	☐ on time	☐ late
Stop using baby talk	☐ early	☐ on time	☐ late
Become toilet trained during the day	☐ early	☐ on time	☐ late
Stop wetting the bed at night	☐ early	☐ on time	☐ late

Was it difficult for this child to:

Identify colors and shapes	☐ no / ☐ yes	Cut with scissors	☐ no / ☐ yes
Ride a 2-wheeled bicycle	☐ no / ☐ yes	Tell time	☐ no / ☐ yes
Climb stairs, hop, or skip	☐ no / ☐ yes	Tie shoes	☐ no / ☐ yes
Use zippers or buttons	☐ no / ☐ yes	Separate from parents	☐ no / ☐ yes
Read aloud in class	☐ no / ☐ yes	Make friends	☐ no / ☐ yes
Say names or sounds of letters	☐ no / ☐ yes	Read	☐ no / ☐ yes
Write letters and numbers	☐ no / ☐ yes	Count or add	☐ no / ☐ yes
Identify right and left	☐ no / ☐ yes	Recite the alphabet	☐ no / ☐ yes

Describe anything else hard for him/her to learn as a preschooler_____

_____

Did family, friends, or teachers ever have difficulty understanding his/her speech? ☐ no / ☐ yes
Explain _____

Medical History

Did this child have any of the following childhood illnesses:

Ear infections ☐ no / ☐ yes age(s) _____ explain_____
Frequent colds ☐ no / ☐ yes age(s) _____ explain _____
Allergies ☐ no / ☐ yes age(s) _____ explain _____
Meningitis ☐ no / ☐ yes age(s) _____ explain _____
Encephalitis ☐ no / ☐ yes age(s) _____explain _____
Whooping cough ☐ no / ☐ yes age(s) _____explain _____
Scarlet fever ☐ no / ☐ yes age(s) _____explain _____
Pneumonia ☐ no / ☐ yes age(s) _____explain _____

Has this child received any blows to the head ☐ no / ☐ yes When?
_____

Was the child unconscious? ☐ no / ☐ yes For how long?_____

Has this child ever had seizures? ☐ no / ☐ yes Age(s) _____

Did this child receive medication for seizures? ☐ no / ☐ yes Specify _____

When was the last seizure? _____

Is there a known cause for the seizure(s)? _____

Has this child ever been evaluated or treated for any stress, anxiety, depression, or other types of psychological problems? ☐ no / ☐ yes Specify _____

Has this child ever had other injuries or accidents requiring medical treatment? ☐ no / ☐ yes

Specify _____

_____

Has this child ever been hospitalized? ☐ no / ☐ yes Age(s)_____

Why and for how long? _____

Current Medical Status

Describe this child's present health _____ Last physical exam _____

Has the child been on medication (other than routine antibiotics) in the last 5 years? ☐ no / ☐ yes

Is this child currently taking any medication? □ no / □ yes If yes, describe below.

Name	Dosage	Reasons Prescribed

How is this child's appetite? _____

Any recent changes (increased or decreased)? □ no / □ yes Describe _____

Average amount of sleep at night _____ Is this adequate for child to function well? □ no / □ yes

Any recent changes (increased or decreased)? □ no / □ yes Describe _____

Are there concerns with this child's hearing? □ no / □ yes Last hearing evaluation (date) _____

Are there concerns with this child's vision? □ no / □ yes Last vision evaluation (date) _____

Educational History

Has this child ever:

Been diagnosed with a learning disability	□ no	□ yes	□ don't know
Been diagnosed with Attention Deficit Disorder (ADD/ADHD)	□ no	□ yes	□ don't know
Skipped a grade in school	□ no	□ yes	□ don't know
Been retained or repeated a grade in school	□ no	□ yes	□ don't know
Received poor or failing grades	□ no	□ yes	□ don't know
Disliked or refused to do homework	□ no	□ yes	□don't know
Disliked or refused to go to school	□ no	□ yes	□don't know
Been referred for special education	□ no	□ yes	□don't know
Been tested for special education	□ no	□ yes	□don't know
Received special education services (had an IEP)	□ no	□ yes	□don't know
Had a 504-accommodation plan	□ no	□ yes	□don't know
Been truant or missed an extended amount of instruction	□ no	□ yes	□don't know
Been suspended or expelled from school	□ no	□ yes	□don't know

If yes to any of the above, please explain _____

_____

_____

_____

Prior evaluations:

List any prior evaluations that have been completed (e.g., speech, psychoeducational, cognitive, neuropsychological)

Type of evaluation	Date Completed	Examiner/Facility (e.g., school/clinic)

List all schools attended, including any day care centers and preschools

School/Agency Name	City/State	Years There	Age/Grade

What things were hard for this child to learn in elementary school (such as reading, math, writing cursive, succeeding in physical education, making and keeping friends, conduct, completing seatwork)?

_____

_____

How do/did this child's elementary school teachers describe him/her? ___

_____

_____

What things were hard for this child in middle and high school (such as writing compositions, reading long assignments, social skills, oral presentations, foreign language, algebra, geometry, study skills)?

_____

_____

How do/did this child's middle and high school teachers describe him/her? _____

_____

_____

Describe any behavior or conduct problems during the elementary and secondary school years_____

_____

_____

High school GPA _____ Average English grades _____Average math grades _____

High school foreign language instruction

Language _____ Number of years _____ Average grades_____

Language _____ Number of years _____ Average grades_____

List any honors, awards, or other kinds of special recognition this child has received _____

_____

Best SAT score (if taken) Verbal _____ Math _____

Was test ☐ timed / ☐ untimed / ☐ extended time prep course: Specify_____

Best ACT score (if taken) _____

Was test ☐ timed / ☐ untimed / ☐ extended time prep course: Specify_____

List any services (such as special education, tutoring, extra help) that have ever been provided, including the type (resource or self-contained special education, tutoring, special school), frequency and duration. Also indicate the skills/subjects for which the child received, or is receiving, help.

_____

_____

Child's best subjects _____

Child's poorest subjects_____

Does this child have any trouble doing his/her homework? ☐ no / ☐ yes Describe _____

How are problems with homework usually handled?_____

Social/Emotional and Behavioral Functioning

How would other children describe this child? _____

_____

Describe this child's friendships (leader/follower, easy to get along with, older/younger friends)

_____

Describe any problems in friendships (such as teasing, aggressiveness, rejection) _____

_____

Does this child feel accepted by Peers ☐ no / ☐ yes Parents ☐ no / ☐ yes Siblings ☐ no / ☐ yes Describe_____

_____

What kinds of activities/tasks does this child enjoy? _____

_____

What are the child's current extracurricular activities? _____

_____

What makes this child feel guilty? _____

Does he/she often feel that way? _____

How does this child show affection?_____

Is it hard for this child to trust other people? ☐ no / ☐ yes

Does he/she feel comfortable around others? _____

How often does this child feel angry? What makes him/her feel that way? What does he/she do when angry? _____

_____

Is this child a worrier? ☐ no / ☐ yes What types of types of things does he/she worry about?

_____

Describe any nervous habits (such as nail biting, thumb sucking, hair pulling)

_____

Would you describe this child as obedient, or compliant with requests? ☐ no / ☐ yes

How is he/she punished? _____

Is it effective?_____

Describe any unusual or problem behaviors not described above _____

_____

Are there any recent changes or current stressors in this child's life, or in the family? ☐ no / ☐ yes

Describe_____

_____

Are there any other adults that this child regularly spends time with?_____

Related Issues

This child's reaction/thoughts about this evaluation _____

_____

Comments from this child's physician about this child's (a) difficulties and (b) this evaluation

_____

Comments from other therapists/professionals _____

_____

What do you think a learning disability is? _____

_____

How have you and/or this child coped with his/her learning problems? _____

_____

_____

How does this child best learn things? _____

_____

_____

What are this child's strengths?_____

_____

_____

What do you believe is the cause(s) of this child's difficulties? _____

_____

Additional comments _____

_____

_____

_____

I have provided complete, true, and accurate information to the best of my knowledge. I understand that false or inaccurate information may invalidate my child's evaluation. I also understand that information on this form, and any information provided as part of this evaluation, can be released only to individuals designated by me and with my written consent, and that my consent can also be revoked by me, in writing, at any time.

_____ _____

Signature Date