Counseling Services of Southern Minnesota

Child Psychological Assessment Intake Form

PATIENT INFORMATION

Child's name: _____ Preferred Name: _____

First Name Last Name

Date of Birth: _____/_____/_____ Age: _____ Sex: **Male** **Female**

Child's ethnicity/race (optional):

☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Asian

☐ Hispanic or Latino ☐ Black or African American ☐ White or Caucasian

☐ Multiracial

Primary language spoken at home: _____

Secondary language spoke at home (if applicable): _____

CONTACT INFORMATION

Name of person completing this form: _____ Today's date: _____/_____/_____

Relationship to child: _____

REFERRAL INFORMATION AND PRESENTING CONCERNS

Is this referral related to any type of legal or court proceeding? **No** **Yes**

Who referred you for a psychological assessment? _____

What are your primary concerns about your child?

1. _____
2. _____
3. _____

When did you first have these concerns? _____

_____

FAMILY INFORMATION

Caregiver Name: _____ Age _____

Relationship: **Biological parent** **Stepparent** **Adoptive/foster parent** **Other:**

Highest grade completed: _____ Primary/Secondary Language: _____

Occupation _____ **Fulltime** **Part-time**

Caregiver Name: _____ Age: _____

Relationship: **Biological parent** **Stepparent** **Adoptive/foster parent** **Other:**

Highest grade completed: _____ Primary/Secondary Language: _____

Occupation _____ **Fulltime** **Part-time**

Child lives with (circle all that apply): **Father** **Mother** **Other:** _____

Parents are: ☐ Married (Number of years: _____) ☐ Separated (Date: _____/_____/_____)

☐ Divorced (Date: _____/_____/_____) ☐ Never married ☐ Living together

☐ Widowed (Date: ___/____/___)

If parents are separated or divorced, please select the applicable custody status:

☐ Sole legal ☐ Joint legal ☐ Sole physical ☐ Joint physical ☐ N/A

Have the parental rights of the parents ever been terminated? **No** **Yes**

Other parent(s)/stepparent(s)/caregivers:

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Siblings:

Name	Age	Relationship (e.g., brother)	Lives with child? Y/N

Do any other individuals live with the child? **No** **Yes**: _____

_____

Family medical history is an important part of developing a plan of care for your child. Please indicate if anyone in your family has the following conditions:

Condition/Circumstance	Relation to patient (e.g., brother)	Mother or father's side
Intellectual disability		
Learning disorder		
Attention-deficit/hyperactivity disorder (ADHD)		
Speech and language impairment		
Seizures/epilepsy		
Alcohol abuse		
Drug abuse		
Physical/emotional/sexual abuse		
Depression		
Suicide attempt		
Obsessive-compulsive disorder		
Anxiety		
Bipolar disorder		
Schizophrenia		
Tics or Tourette's syndrome		
Autism spectrum disorder		
Genetic disorder		
Special education services		
Arrests/incarcerations		
Other:		

Does the family identify with a faith or spiritual community? No Yes: _____

_____

Please list any recent stressors, legal issues, or crises that may be affecting the family and/or child (e.g., death in family, divorce, illness, financial difficulties, custody disputes, recent move):

_____

_____

PREGNANCY AND BIRTH INFORMATION

Age of mother at time of birth: _____ Age of father at time of birth: _____

Did mother receive prenatal care? No Yes

Mother's health during the pregnancy was: Good Fair Poor Unknown

Do you recall any of the following being used during pregnancy?

☐ Drugs ☐ Alcohol ☐ Tobacco ☐ Coffee/caffeine ☐ Prescription medications

☐ X-Rays ☐Unknown If yes, please list medications/substances: _____

_____

Did the mother experience any significant illness, injury, or complications during pregnancy (e.g., toxemia, eclampsia, Rh factor incompatibility)? No Yes Unknown

If yes, please explain: _____

_____

The patient was born: ☐ on time ____ weeks early ____ weeks late

Length of labor (in hours): _____

Delivery: ☐ Vaginal ☐ C-section ☐ Forceps ☐ Vacuum assist ☐ Induced

☐ Breech ☐ Drugs used to assist with labor/delivery: _____

Was there anything unusual about the delivery or birth? No Yes Unknown

If yes, please explain: _____

_____

Baby's birth weight: _____ Baby's birth length: _____

Apgar scores: _____ at 1 minute and _____ at 5 minutes

Were there any problems after birth or signs of infant distress (examples: jaundice, need for oxygen, infections, feeding problems, seizures)? No Yes: _____

_____

Were there any health complications following birth? No Yes: _____

_____

DEVELOPMENTAL INFORMATION

Please describe your child's temperament at the following ages:

Infancy (birth to 12 mos.): ☐ Pleasant/happy ☐ Fussy/colicky ☐ Other:

Toddler (12 to 36 mos.): ☐ Pleasant/happy ☐ Fussy/colicky ☐ Other:
Preschool (36 to 60 mos.): ☐ Pleasant/happy ☐ Fussy/colicky ☐ Other:

In the first year, did your infant experience any of the following:
☐ Breathing problems ☐ Feeding problems ☐ Sleep difficulties ☐ Separation problems
☐ High activity level ☐ Short attention span ☐ Difficult to comfort ☐ Attachment difficulties
☐ Health problems ☐ Alertness problems ☐ Difficult to put on a schedule
If you checked any of these boxes, please explain: _____

_____

Did preschool teachers, daycare providers, or other caregivers observe difficulty with any of the following:
☐ Structured activity ☐ Peer relationships ☐ Attention ☐ Behavior ☐ Transitions

At what age did your child first do the following?

Milestone	Age Achieved	Milestone	Age Achieved
Smile		Babble	
Sit alone		Crawl	
Walk alone		Respond to name	
Say single words		Say 2–3-word phrases	
Read words		Feed self with utensils	
Dress self		Ride 2-wheel bike	
Daytime toilet trained (bladder)		Daytime toilet trained (bowel)	
Nighttime toilet trained (bladder)		Nighttime toilet trained (bowel)	

Has your child ever gained skills and then lost them in any developmental area (e.g., language, toileting, motor skills?) **No** **Yes**: _____

_____

If your child is talking, is he or she easy to understand? **No** **Yes**
If you child does not speak, how does he or she communicate? _____

_____

MEDICAL AND PHYSICAL HISTORY:

What is the current health status of your child? **Excellent** **Good** **Fair** **Poor**

Has your child had any of the following? (check all that apply):

☐ Head injury/concussion ☐ Asthma ☐ Lead poisoning ☐ Diabetes ☐ Seizures
☐ Vision problems ☐ Ear tubes ☐ Heart Condition ☐ Broken bones
☐ Hearing problems/loss ☐ Other: _____

Does your child have any history of hospitalizations, surgeries, serious or chronic illness? **No** **Yes**:

_____

_____

Does your child experience any of the following difficulties with sleep? (Check all that apply):

☐ Difficulty falling asleep ☐ Waking in the night ☐ Nightmares/night terrors ☐ Snoring

☐ Sleeps too much ☐ Restless ☐ Early morning waking

☐ Falls asleep during the day (other than age-appropriate naps)

Does your child have any of the following feeding/appetite issues? (Check all that apply):

☐ Gagging ☐ Vomiting ☐ Overeats ☐ Picky Eater ☐ Avoids food due to texture

☐ Odd eating behavior/habits ☐ Under eats

Is constipation a problem? **No** **Yes**

Does your child have problems with gross motor (e.g., running, jumping) or fine motor (e.g., fastening buttons, holding a pencil) coordination? **No** **Yes**

Does your child have any pain issues or concerns? **No** **Yes**: _____

_____

Are your child's immunizations up to date? **No** **Yes** **Unknown**

MEDICATIONS

List all **current** medicines, supplements and homeopathic remedies you child is currently taking:

Medication	Dose	Purpose	When started

List any **past** medications:

Medication	Dose	Purpose	When started & ended

MEDICAL AND MENTAL HEALTH SERVICES

Please indicate if the child has participated in any of the following evaluations:

Type	Date	Agency	Results/Diagnoses
Diagnostic Assessment			
Feeding Therapy Evaluation			
Genetic Testing			
Neurological Evaluation			

Neuropsychological Evaluation			
Psychological Evaluation			
Occupational Therapy Evaluation			
Physical Therapy Evaluation			
Psychiatric Evaluation			
Speech Therapy Evaluation			

Please indicate if the child has participated in any of the following services:

Type	Dates	Agency
Applied Behavior Analysis (ABA)		
Day Treatment		
Family Therapy		
Individual Therapy		
Group Therapy		
Skills		
Feeding Therapy		
Occupational Therapy		
Partial Hospitalization		
Physical Therapy		
Psychiatric Hospitalization		
Psychiatry/Medication Management		
Speech Therapy		

***** Please provide copies of any past reports/evaluations at the first appointment*****

EDUCATIONAL INFORMATION

Is your child currently enrolled in school? **No** **Yes**

School: _____ Grade: _____

Does your child receive additional educational supports (e.g., special education services)? **No** **Yes**

If "yes", under what category did your child qualify for special education: _____

Are you satisfied with the services your child has received at school? **No** **Yes**

Has the school voiced any behavioral or academic concerns? **No** **Yes**: _____

_____

What grades does the child usually receive in school? _____

Has your child experienced any of the following?

☐ Delayed kindergarten entry ☐ Retained in grade ☐ In school suspension

☐ Out of school suspension ☐ Expulsion

***** Please provide copies of any special education evaluations, 504 Plans, or IEPs*****

Does the child attend daycare or a childcare center? **No Yes**

SOCIAL INFORMATION

Does your child interact with other children? **No Yes**

Do you have concerns with how your child plays or interacts with other children? **No Yes**:

_____

_____

Does your child have any problems getting along with others? **No Yes**:

_____

_____

How many close friends does your child currently have? _____

Check all that apply:

☐ Difficulty making friends ☐ Difficulty keeping friends ☐ Few friends ☐ Bullied

☐ Not respectful of authority ☐ Prefers to play alone ☐ Plays mainly with older children

☐ Plays mainly with younger children

BEHAVIORAL INFORMATION/SYMPTOMS OBSERVED

Please place a mark next to behaviors that you believe your child exhibits to an *excessive or exaggerated degree* when compared to other children his or her age.

	Hyperactivity		Inattention		Impulsive
	Engages in dangerous activities		Loses temper		Argues with adults
	Defiant/oppositional		Easily annoyed		Spiteful/Vindictive
	Swears		Steals		Runs away from home
	Lies		Fire setting		Truant
	Destroys property		Cruel to animals		Cruel to people

	Physical fights		Worry		School refusal
	Refusal to sleep alone		Nightmares		Stomachaches
	Headaches		Self-conscious/low self-esteem		Inability to relax
	Depressed mood		Irritable mood		Diminished pleasure in activities
	Increase in appetite		Lack of appetite		Difficulty falling asleep
	Difficulty waking in the morning		Wakes in night		Sleeping too much
	Low energy		Feelings of worthlessness/guilt		Suicidal ideation
	Hopeless		Repetitive motor movements		Overreacts to noise, light, sound, smell, touch
	Compulsive rituals		Tics		Delusions
	Hallucinations		Frequent temper tantrums		Clingy
	Difficulty in self-care		Panic attacks		Lack of facial expressions
	Lack of interest in peers		Intense interest in objects or topics		Rigid thinking
	Dislikes change in routine		Shy		Cries frequently
	Obsessive thinking		Dislike certain textures		Self-harm statements
	Self-harm actions		Suicide attempt		Aggression towards others

Please indicate if you have any further concerns regarding your child's behavior: _____

_____

What do you enjoy most about this child? _____

_____

TRAUMA/STRESSORS

Has your child experienced neglect or abuse? **No** **Yes** **Suspected** **Unknown**

Is there history of CPS involvement/foster care? **No** **Yes**

Have there been any recent stressful life events?

☐ Divorce/separation ☐ Financial problems ☐ Substance abuse ☐ Death of family or friend

☐ Marriage ☐ Change in job status ☐ Relationship conflict ☐ Other: _____

LEGAL ISSUES

Has the child been involved in any legal issues? No Yes: _____

_____

CHEMICAL USE

Do you have any concerns about your child using alcohol or other drugs? No Yes: _____

_____

Please fill out and bring the completed form and records to your appointment.