

Debra Kessler, Psy.D., R.N., M.N.

Specializing in children with emotional & developmental challenges
Clinical Psychologist, L.I.C. PSY 19100
(818) 248-6414

INTAKE

Child's Name: _____ Age: _____ DOB: _____
Address _____

Gender: M F School Attended: _____

Parent 1: Home Phone: _____ Cell Phone: _____

Parent 2: Home Phone: _____ Cell Phone: _____

E-Mail address: Parent 1: _____ Parent 2: _____

Please indicate how you (parent 1) wish to be contacted:

Home phone YES NO Cell phone YES NO E-mail YES NO

Please indicate how you (parent 2) wish to be contacted:

Home phone YES NO Cell phone YES NO E-mail YES NO

PRESENTING PROBLEM:

What are the concerns that have brought you to the office: _____

When did this first become a problem/concern? _____

Are there recent events/changes in your child's life (home, school, family, health, routine) that seem to have impacted your child's behavior? YES NO

If YES, please describe: _____

Past efforts to address the concern (please include ALL professional you have worked with in the past or are currently working with to address the concern): _____

Please describe times when your child's behavior is more challenging: _____

Please describe times when your child's behavior is not problematic: _____

Is the child currently on any medication for the problem? YES NO
If yes, please list all medications and prescribing physician _____

FAMILY HISTORY:

Parent 1

Name _____ Age: _____ Occupation: _____

Education _____ Number of Marriages: _____

Any significant medical problems? YES NO

If YES, please describe: _____

Any present or previous psychiatric treatment or counseling: YES NO

If YES, reason for treatment and how long ago: _____

Any family members have emotional problems or learning disabilities (depression, bipolar disorder, hospitalization for a mental health problem, suicide, etc.) YES NO

If YES, please describe _____

Any history of substance abuse (drug or alcohol)? YES NO

If YES, please explain: _____

Parent 2

Name _____ Age: _____ Occupation: _____

Education _____ Number of Marriages: _____

Any significant medical problems? YES NO

If YES, please describe: _____

Any present or previous psychiatric treatment or counseling: YES NO

If YES, reason for treatment and how long ago: _____

Any family members have emotional problems or learning disabilities (depression, bipolar disorder, hospitalization for a mental health problem, suicide, etc.) YES NO

If YES, please describe _____

Any history of substance abuse (drug or alcohol)? YES NO

If YES, please explain: _____

Marital status of parents:

Currently together Separated Divorced Widowed Single

Date of marriage _____ Date of separation _____ Date of divorce _____

Who has legal custody? _____ Primary physical custody? _____

Please list individuals living in the household: Names, birthdates and relationship to client:

Names	Relationship to client	Birthdate
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any children not currently living with you? YES NO

Have there been any recent changes in the family group? YES NO

Death of a family member?

Date: _____

Sharing home with relatives of friends?

Date: _____

Changes in residence since child's birth? YES NO

Prolonged absence or illness of either parent? YES NO

If YES, date/duration: _____

Who usually cares for your child when parents are unavailable to do so?

MEDICAL HISTORY OF THE CHILD:

Pregnancy: _____ Conception unassisted Conception assisted Adopted

Has the child ever had any serious illness, accidents or operations? YES NO

If YES, please describe each incident and specify child's age: _____

Is child allergic to any foods, medications, pollens, dust or other substances? YES NO

If YES, please describe: _____

DEVELOPMENTAL HISTORY

Was the child planned? YES NO

How did parent 1 feel about having a child?

How did parent 2 feel about having a child?

Did mother work during pregnancy? YES NO

If yes, how long? _____

Was the child full term? YES NO

Apgar Scores? _____

If NO, how many weeks at delivery? _____

Did the mother have any medical or emotional problems during pregnancy (for example, convulsions, hemorrhages, have premature labor requiring bed-rest/medication, falls, high conflict at home):

Where there any complications of labor and delivery? YES NO
If YES, please describe: _____

Did he/she come home from the hospital with mother after delivery? YES NO
If NO How long did baby stay in the hospital after mom was discharged?

Birth weight: _____. Where there any complications after the baby was born? YES NO"
(For example: difficulty breathing, baby cyanotic, RH incompatibility, jaundice?)
If YES, please describe: _____

During the baby's first year of life, was there anything (even if it had nothing to do with the baby) that caused the mother unhappiness or anxiety or that placed her under strain?
_____ a

How soon after birth did mother return to work? _____ aa

How did the child as a baby sleep in the first year of life? _____

Where did the child as a baby sleep the first year of life? _____

When did the child as a baby first sleep through the night? _____

Please describe your child's sleep pattern:

- Goes to sleep independently
- Needs parent to be present in child's room to fall asleep
- Co-sleeps with parents
- Goes to sleep in own room, but wakes up in parent's bed
- Sleep walks
- Has nightmares
- Has night terrors
- Difficulty falling asleep
- Difficulty staying asleep
- Difficulty waking up in morning
- Able to sleep through the night
- Child has/uses technology within an hour of sleep
- Other: _____

How long does it take for your child to fall asleep? _____

How many hours of sleep does your child get each night? _____

How is it for your child in the morning?

- Wakes up without assistance, quick to be alert
- Needs parent to wake up, quick to be alert
- Wakes up too early, before anyone else
- Difficult to awaken but child becomes alert
- Difficulty to awaken and child falls back asleep
- Child is hostile/aggressive upon waking
- Other _____

FEEDING/ORAL/SPEECH

Was baby breast feed YES NO If yes, for how long: _____ When weaned: _____

Were there any feeding problems (colic, diarrhea, food allergies?) YES NO
If YES, please explain: _____

Is your child a “picky” eater? (ie: demands particular brands/types of foods) YES NO
If YES, please describe: _____

Have there been any foods that your child avoids (crunchy or slimy foods)? YES NO
If YES, please describe: _____

Is your child on any special diet? YES NO
If YES, please describe: _____

Does your child have concerns about weight? YES NO
If YES, does your child have “odd” eating habits, demonstrate food restrictions (time of day they will/will not eat, food restriction, sneaking/hiding food/sweets, etc) _____

Did/does the child thumb suck? YES NO

Have there been any concerns about the child’s language development such as:

- Doesn’t talk Lisp
- Delayed speech Repeating syllables
- Mispronouncing words Stuttering

MOTOR DEVELOPMENT:

When did the child: Sit up _____, Crawl _____, Walk _____, Talk _____,

Who took primary responsibility to toilet training? _____

At what age was bowel training begun? _____ Completed? _____

At what age was bladder training begun? _____ Completed? _____

Was your child’s toilet training ever a problem? YES NO
If YES, please explain: _____

Is the child primarily Right handed Left handed

SEPARATIONS:

How has the child responded to separations?

Was the child placed in Day-Care or Pre-School? YES NO

If YES: At what age? _____ How many hours/day, days/week? _____

Has your child received childcare at home? YES NO

If YES: At what age? _____ How many hours/day, days/week? _____

Were there changes in childcare providers?

Is your child's behavior the same in all settings/with all members of the family? YES NO

If NO, please describe _____

SCHOOL INFORMATION:

Were there/are there problems at pre-school/day-care? YES NO

If YES, please describe: _____

Does your child have behavior problems in school now? YES NO

If YES, please describe: _____

Does your child have learning problems in school? YES NO

If YES, please describe: _____

Has your child ever been put ahead or kept behind in school? YES NO

If YES, please describe: _____

SOCIAL HISTORY:

How is discipline practiced in your home with your child? _____

Is there a difference in mother's approach and father's approach to discipline?

How does your child respond to transitions? _____

Which activities does your child participates in and number of hours/week?

	Hours/week
Sports/outdoor activities:	
Areas of particular interests/expertise (Legos/dinosaurs/trains/history/etc.)	
Interactive gaming technology (Video games/DS/Wii/Xbox/etc.):	
Interactive technology/media use (snapchat/twitter/instagram/etc.):	
Passive technology use (TV, Youtube, etc.):	

Does your child make friends primarily with children his/her own age? YES NO
 If NO, please indicate: younger children? older children? adults?

Does your child have a best friend(s)? _____

Describe how your child tantrums/protests.
 (Include: cause, frequency, intensity and duration: Describe typical and worst episodes)

Describe how tantrums/protests/upsets are resolved:

Describe what gives your child joy and what you do together that is joyful:

Describe how your child is calmed and soothed (back rubs, water, rocking chair, etc.):

PARENT PERSPECTIVE:

The qualities I most like about my child are:
