PSYCHOLOGICAL TESTING INTAKE – CHILD/ADOLESCENT

Client's Name: _____ DOB: _____ Age: _____ Grade: _____

Race and Ethnicity: _____ Gender Identity: _____

Name(s) of Informants: _____ Relationship: _____

Date of Interview: _____

Why are you seeking psychological assessment services? _____
_____
_____
_____

BIRTH HISTORY

Prenatal history (Check all that apply and specify type, amount/dosage or number, and duration for each category):
Planned_____Smoking_____Alcohol_____Medications_____
Vitamins _____Other substances_____

Complications during pregnancy (e.g., required bed rest)? _____
_____

Parinatal history:

Full term/other (Y/N) _____ Medical Complications during labor (e.g., Preclampsia)?
_____
_____

Delivery (e.g., natural, induced, C-Section) _____

Delivery Complications_____

Postnatal history:

Height _____Weight _____ Hospital Stay_____

Complications after birth (e.g, NICU stay , jaundice, feeding issues, etc.)?
_____

PSYCHOLOGICAL TESTING INTAKE – CHILD/ADOLESCENT

DEVELOPMENTAL HISTORY

Early development problems (e.g., colic, eating difficulties, sleep problems; sleep alone? How long breast fed?) _____
_____
_____
_____
_____

Developmental Milestones (Please specify in months):

Roll over _____ Sit Up _____ Crawling _____
1st Steps Unassisted _____ Independent Walking_____
First Words _____ 3-Word Sentences_____ Toilet Training_____

Early **Temperament** (describe child's interactions with caregivers and environment including eye contact, ability to be comforted, use and reaction to gestures, social bonding):

_____
_____

Please respond to the following based on the child's behavior when they were a toddler:

Activity Level (Check one)
____ Able to sit still and play alone
____ Relaxed and average activity level
____ Constantly moving, on the go, fidgety

Attention Span (Check one)
___ Distractible - notices everything, moves from thing to thing, daydreams
___ Persistent - able to stay on task

Frustration Tolerance (Check one)
___ Low - easily frustrated and upset by failure or being told no
___ High – appropriately responsive to failure or being told no

Reaction (Check one)
___ Withdrawn - shyness, response to new situations, slow to warm/cautious
___ Approachable - bold and daring

Adaptability
___ Easily adapts and adjust to changes in the environment
___ Resistant to change and needs excessive time to settle into a new routine

PSYCHOLOGICAL TESTING INTAKE – CHILD/ADOLESCENT

Reactivity
___ Mild reaction to emotions, generally calm
___ Intense reaction to emotions, easily agitated

Regularity
___ Typical sleeping, eating, and bathroom patterns?
___ Atypical sleeping, eating, and bathroom patterns (please specify): _____
_____

Sensory Threshold
___ Low or no sensitivity to noises, temperatures, tastes, textures; picky, focuses on discomfort
___ High sensitivity to sensitivity to noises, temperatures, tastes, textures; picky, focuses on discomfort

Mood
___ Positive general outlook, cheerful, smiles often
___ Negative general outlook, sullen, cries often

Noticeable changes in Temperament (behavior and mood)? When?
_____
_____
_____
_____

FAMILY/ENVIRONMENTAL HISTORY

Is this child adopted? □ Yes □ No Are they aware? □ Yes □ No

Please briefly describe the circumstances of adoption (e.g., open adoption, closed adoption, international or domestic adoption, etc.)

_____
_____
_____

Parent/Guardian Full Name: Age: Place of Birth:

Occupation/Work Title: Employer:

Health, behavioral, learning, or substance problems:

Parent/Guardian Name: Age: Place of Birth:

PSYCHOLOGICAL TESTING INTAKE – CHILD/ADOLESCENT

Relationship to Child:

Occupation/Work Title: Employer:

Any health, behavioral, learning, or substance problems:

Child's parents are: □ Married □ Divorced □ Separated □ Never Married

*****Please bring custody or court papers to the first appointment, if applicable******

Custody arrangements/visitation schedule?_____

Please list all brothers and sisters, including full, half and step-siblings:

Name of Sibling	Relationship to child	Age	Gender	Live in the home?

List any other members of the household and other important persons in child's life:

Family Member's Name	Relationship to child	Age	Gender	Live in the home?

Recent Stressors to self/family: _____

_____

Daily Schedule: _____

_____

PSYCHOLOGICAL TESTING INTAKE – CHILD/ADOLESCENT

Cultural Considerations

1. Please describe any important cultural or religious customs or values that should be taken into consideration during this evaluation:

2. Has anything prevented you from getting the help you need? For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or cultural identity?

CURRENT BEHAVIORS AND SYMPTOMS

Please check all of the behaviors and symptoms that the patient has experienced or is currently experiencing:

- ❑ Poor memory/confusion
- ❑ Panic attacks
- ❑ Sleep problems
- ❑ Seasonal mood changes
- ❑ Fear away from home
- ❑ Nightmares
- ❑ Sadness/depression
- ❑ Anxiety
- ❑ Social discomfort
- ❑ Hearing voices
- ❑ Aggression/fights
- ❑ Problems with pornography
- ❑ Self-harm behaviors
- ❑ Frequent arguments
- ❑ Parenting problems
- ❑ Crying spells
- ❑ Irritability/anger
- ❑ Alcohol/drug use
- ❑ Fatigue
- ❑ Visual hallucinations
- ❑ Recurring, disturbing memories
- ❑ Change in appetite
- ❑ Suspicion/Paranoia
- ❑ Eating problems
- ❑ Loss of pleasure/interest
- ❑ Obsessive thoughts/behaviors
- ❑ Gambling problems
- ❑ Hopelessness
- ❑ Compulsive behavior
- ❑ Computer addiction
- ❑ Thoughts of death
- ❑ Sexual problems
- ❑ Loneliness
- ❑ Homicidal thoughts
- ❑ Relationship problems
- ❑ Low self-worth
- ❑ Flashbacks
- ❑ Work/school problems
- ❑ Guilt/shame

PSYCHOLOGICAL TESTING INTAKE – CHILD/ADOLESCENT

Please check if the patient has experienced any of the following types of trauma or loss:

- ❑ Emotional abuse
- ❑ Lived in a foster home
- ❑ Violence in the home
- ❑ Physical abuse
- ❑ Homelessness
- ❑ Neglect
- ❑ Sexual abuse
- ❑ Multiple family moves
- ❑ Crime victim
- ❑ Parent substance abuse
- ❑ Parent illness
- ❑ Teen pregnancy
- ❑ Loss of a loved one
- ❑ Placed a child for adoption
- ❑ Financial problems
- ❑ Other (please specify):

Are any of the problems selected above affecting the following?

- ❑ Handling everyday tasks
- ❑ Self esteem
- ❑ Relationships
- ❑ Hygiene
- ❑ Work/School
- ❑ Housing
- ❑ Legal matters
- ❑ Finances
- ❑ Recreational activities
- ❑ Sexual activity
- ❑ Health

Risk Assessment:

❑ Yes ❑ No Have you ever had thoughts, made statements, or attempted to hurt yourself? If yes, please describe:

_____

_____

_____

❑ Yes ❑ No Have you ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe:

_____

_____

_____

❑ Yes ❑ No Have you recently been physically hurt or threatened by someone else? If yes, please describe:

_____

_____

_____

PSYCHOLOGICAL TESTING INTAKE – CHILD/ADOLESCENT

Previous Mental Health Treatment:

Have you previously been seen by a mental health professional: ❑ Yes ❑ No

Provider/Agency Name	When?	Reason for Treatment

MEDICAL HISTORY

(Please describe history, age/grade it occurred, treatment, and outcome for each incident)

Diseases/chronic infections/febrile illnesses: _____

_____

_____

_____

_____

Hospitalizations/ER visits_____

Head injuries/loss of consciousness_____

Surgeries/sutures [specify event and number] _____

Broken bones/other medical problems_____

Allergies_____ Accidental poisonings_____

Medications (current/past) _____

Other medical problems (e.g., seizures, hearing loss, vision problems)_____

_____

Glasses? _____ Eyes checked? _____ Hearing Checked? _____

FAMILY MEDICAL & MENTAL HEALTH HISTORY

Medical history	Who?
❑ Allergies	
❑ Asthma	
❑ Stomach aches	
❑ Surgery	
❑ Head injury	
❑ Meningitis	

❑ Vision problems	
❑ Diabetes	
❑ High blood	
❑ Sleep Disorder	
❑ Headaches	
❑ Chronic pain	
❑ Cancer	
❑ Dizziness/fainting	
❑ Seizures	
❑ Hearing problems	
❑ Other, specify:	

Mental Health History	**Who?**
❑ Hyperactivity	
❑ Inattention	
❑ Learning Issues	
❑ Sexually	
❑ Depression	
❑ Manic	
❑ Suicide	
❑ Anxiety	
❑ Panic Attacks	
❑ Obsessive-	
❑ Anger/Abusive	
❑ Schizophrenia	
❑ Eating Disorder	
❑ Alcohol Abuse	
❑ Drug Abuse	
❑ Other, specify:	

ACADEMIC AND SOCIAL HISTORY

Caregiving History

Prior to formal schooling, who cared for client? _____

Daycare Name: _____ Location: _____
Behavior/Comments: _____

Daycare Name: _____ Location: _____
Provider/Teacher: _____
Behavior/Comments: _____

PSYCHOLOGICAL TESTING INTAKE – CHILD/ADOLESCENT

Education History

Preschool/Kindergarten (Ages: _____; Years: _____)
School/Facility_____ Location_____
Teacher_____ Comments_____
Academic _____
Behavior_____
Social _____

Elementary School (Ages: _____; Years: _____)
School/Facility_____ Location_____
Teacher_____ Comments_____
Academic _____
Behavior_____
Social _____

School/Facility_____ Location_____
Teacher_____ Comments_____
Academic _____
Behavior_____
Social _____

Middle School (Ages: _____; Years: _____)
School/Facility_____ Location_____
Teacher_____ Comments_____
Academic _____
Behavior_____
Social _____

School/Facility_____ Location_____
Teacher_____ Comments_____
Academic _____
Behavior_____
Social _____

High School (Ages: _____; Years: _____)
School/Facility_____ Location_____
Academic _____
Behavior_____
Social _____

PSYCHOLOGICAL TESTING INTAKE – CHILD/ADOLESCENT

School/Facility_____ Location_____
Academic _____
Behavior_____
Social _____

Previous Testing/Assessments (Please describe where, when and purpose):

_____
_____
_____
_____

Special Education History and Placements (Please describe):

_____
_____
_____
_____

Repeated a grade (Please specify which grade(s) and why):

_____
_____
_____
_____

Suspensions/expulsions/school initiated punishments (include age/grade, event, outcome):

_____
_____
_____
_____

Calls home from teachers, communicated concerns:

_____
_____
_____
_____

Dr. Shalena Heard | dr.slheard@gmail.com | (443) 873-0835

PSYCHOLOGICAL TESTING INTAKE – CHILD/ADOLESCENT

SOCIAL FUNCTIONING

Peer Relationships

1. Does the patient prefer friends who are ___ Younger ___ Older

   _____
   _____
   _____

2. Does the patient participate in sleep-overs, play dates, birthday parties, or other age appropriate social gatherings? ___ Yes ___ No
   If no, please explain:

   _____
   _____
   _____

3. Does the patient have the ability to make and maintain friendships? ___ Yes ___ No
   If no, please explain:

   _____
   _____
   _____

Participation in organized sports/activities (e.g., soccer, baseball, swimming, Scouts, karate):

_____
_____
_____
_____

Other preferred activities (e.g., hobbies, computer/video games, art, music, bicycling skateboarding, water sports)

_____
_____
_____
_____

ADDITIONAL INFORMATION

Please provide any additional information, that has not been asked, and may be helpful in my assessment of the child: