

 **Consultants for Children, Inc.**

265 South Harlan Street, Lakewood, CO 80226 (720) 272-1289

Please complete this intake and return it to the office. Attach any and all pertinent information, evaluations, etc. After you have returned information a consultant date can be scheduled.

Family Information

Child's Name: _____ Nickname: _____ Today's Date: _____
Date of Birth: _____ - _____ - _____ Current Age: _____ Gender: ___Male ___Female
Month Date Year Social Security Number: _____ - _____ - _____

Address: _____ Home Telephone: (_____) _____ - _____
Number & Street Apt. #

City State Zip

Father's Name: _____ Date of Birth: _____ - _____ - _____
Month Date Year
Address: _____ Home Telephone: (_____) _____ - _____
Number & Street Apt. #

City State Zip Cell: (_____) _____ - _____

Occupation: _____ Work: (_____) _____ - _____
E-Mail Address: _____

Mother's Name: _____ Date of Birth: _____ - _____ - _____
Month Date Year
Address: _____ Home Telephone: (_____) _____ - _____
Number & Street Apt. #

City State Zip Cell: (_____) _____ - _____

Occupation: _____ Work: (_____) _____ - _____
E-Mail Address: _____

Parents are: Married _____ Separated: _____ Divorced: _____
Who has custody of the client? _____ Is the child adopted? Y N

Please List All Siblings (including client) in Birth Order:

Name: _____	Age: _____	Gender: _____
Name: _____	Age: _____	Gender: _____
Name: _____	Age: _____	Gender: _____
Name: _____	Age: _____	Gender: _____
Name: _____	Age: _____	Gender: _____
Name: _____	Age: _____	Gender: _____
Name: _____	Age: _____	Gender: _____

Family Religious preference: _____

Families Primary Language: _____ Secondary Language: _____

Emergency Contact Name: _____ Phone Number: (_____) _____ - _____
Relationship to family? _____

Developmental History

Describe Pregnancy and Delivery *(please indicate any complications during pregnancy and/or delivery)*

Length of Pregnancy: _____ Client's Birth Weight: _____ lbs. _____ oz.

List any childhood illnesses, *(Please list the child's age, the illness, and the treatment prescribed)*:

List the onset of these developmental milestones:

Crawling: _____

Sitting: _____

Walking: _____

Sleeping Through the Night: _____

Eating Solid Foods: _____

Speech: _____

Toilet Trained: _____

How does your child sleep now?

How does your child eat now?

Describe your child's typical diet:

Has there been past diets your child has tried? If so, please state the type, reason and outcome of that diet:

Does your child drink milk? Y N Type: Cow Soy Rice Goat

Have you seen a link between your child's past medical problems and his/her increasing severity of behaviors?

What do you think "caused" their disability?

Has your child received all of their immunizations to date? Y N

Self Help Skills

Please list your child's current level of functioning on the following skills:

Toileting:

Feeding:

Dressing:

Grooming:

Medical History

Current Clinicians (please provide any reports available from the following listed)

Pediatrician: _____ Telephone: (____) _____ - _____

Immunologist: _____ Telephone: (____) _____ - _____

Allergist: _____ Telephone: (____) _____ - _____

Neurologist: _____ Telephone: (____) _____ - _____

Psychologist: _____ Telephone: (____) _____ - _____

Psychiatrist: _____ Telephone: (____) _____ - _____

Speech Pathologist: _____ Telephone: (____) _____ - _____

Occupational Therapist: _____ Telephone: (____) _____ - _____

CCB Caseworker: _____ Telephone: (____) _____ - _____

Other: _____ Telephone: (____) _____ - _____

Insurance Information

Insurance Company: _____ Policy Number: _____
(please provide a copy of the insurance card)

Diagnostic Testing

Please provide information relating to any medical testing your child may have undergone. List date, who conducted the test, and test results.

Blood Tests:

Audiogram (hearing test) or Vision tests:

Genetic Testing:

Psychological Testing (including IQ testing):

Immunological/Allergy (any known allergies?):

Describe your child's current physical health:

Has your child had any hospitalizations? Y N

If yes, please describe:

Has your child had any surgeries? Y N

If yes, please describe:

Does your child have seizures? Y N

If no, has your child had seizures in the past? Y N

If yes, please indicate frequency of seizures: _____

Length: _____ Type: _____

Is your child currently taking seizure medication? Y N

If yes, please list medication(s):

1. _____
Medication Start Date

2. _____
Medication Start Date

Is your child currently taking any other medications? Y N

If yes, please list medications (include homeopathic, herbal or vitamin-based remedies):

1.	Medication	For Treatment of	Start Date	Dosage
2.	Medication	For Treatment of	Start Date	Dosage
3.	Medication	For Treatment of	Start Date	Dosage
4.	Medication	For Treatment of	Start Date	Dosage

Has your child previously taken any other medication(s)? Y N

If yes, please list:

1.	Medication	For Treatment of	Start Date	Dosage
2.	Medication	For Treatment of	Start Date	Dosage
3.	Medication	For Treatment of	Start Date	Dosage
4.	Medication	For Treatment of	Start Date	Dosage

What medications have been effective and how were they helpful?

Are there negative side-effects of current medications?

Are there any upcoming medication changes that you know about?

List other family members history of psychiatric diagnoses:

Relationship to child: _____ Diagnosis: _____ Severity: _____

Other information: _____

Relationship to child: _____ Diagnosis: _____ Severity: _____

Other information: _____

Relationship to child: _____ Diagnosis: _____ Severity: _____

Other information: _____

Relationship to child: _____ Diagnosis: _____ Severity: _____

Other information: _____

General Behavior

When does your child best listen to parent instruction?

Non-Compliance: Y N

Describe the context in which it usually occurs:

Consequences Used: _____

Tantrums: Y N

Describe the context in which it usually occur:

Describe nature of tantrum (*i.e., throws self on floor, etc.*):

Duration of typical tantrum: _____ Frequency: _____

Consequences Used: _____

Aggression: Y N

Towards Self _____ Towards Others _____ Towards Property _____

Describe context in which it usually occurs:

Describe nature of aggressive behaviors:

Frequency: _____

Consequences Used: _____

Running Away: Y N

Describe context in which it usually occurs:

Frequency: _____

Consequences Used: _____

Other Behaviors:

Behavior: _____

Frequency: _____

Consequences Used: _____

Self Stimulatory Behaviors

Repetitive Mannerisms: (hand flapping, flicking, gazing, lining up objects, hoarding objects, toe walking, running back and forth, etc.):

Unusual attachments to objects:

Repeats previously heard words out of context (echolalia):

Verbalizing in a repetitive manner (i.e. eee sounds, babbling, screaming, etc.):

Difficulty with transitions or changes in routine:

Unusual interest in the sight, feel, sound, or smell of things:

Unusual preoccupations/obsessions (anything he/she likes to do repeatedly):

Social Behavior

Does your child show you affection? How?

How does your child play with other children?

How does your child play with toys?

Please list your child's favorite toys, activities, music, food, games, etc:

Does your child give eye contact? Y N

Whom does your child have good eye contact towards?

Under what circumstances is the eye contact given?

Does your child respond to his/her name? Y N

Does your child come to you for comfort? Y N

Does your child greet you in anyway when he/she sees you? Y N How?

Does your child show interest in other people? Y N

Please indicate whom and how your child shows interest in other people:

Does your child attempt to involve you in something he/she is doing? Y N

Please describe some examples:

Does your child get involved with something you are doing? Y N

Please describe some examples:

Does your child respond better to any particular person? Y N

To whom? _____ Why do you think that is? _____

General Language

Did your child have speech that he/she lost? Y N

If yes, at what age did he/she start to lose speech? _____

Was he/she ill at the time of loss? Y N

What is your child's usual way of communicating?

Does your child cry to let you know if he/she wants something? Y N

Does your child take you or point to what he/she wants? Y N

Does your child say what he/she wants? Y N

Receptive Language

Does your child follow verbal instructions without visual cues? Y N

How much do you think your child understands?

Expressive Language

Does your child have any words? If yes, please give examples:

Are the words your child has used in context or out of context?

Does your child babble or combine sound so that the combined sounds resemble some speech?

Are there any words that your child imitates? If yes, please list the words:

What is the average length of your child's utterances?

Are there problems with your child's articulation or intonation of speech?

Can your child hold a conversation about a favorite topic? Y N

If yes, please describe:

Please list any additional comments you would like to make regarding your child's speech and language:

Educational Background

Does your child attend school? Y N

What is the name of the school? _____

What type of program does your child attend?

How long has your child been attending school? _____

Does your child have an aide/shadow while attending school? Y N

If yes, is the aide/shadow with your child full or part time? _____

Is there a current IEP? (If so, please provide a copy) Y N

Are you satisfied with the school program? Y N

Explain: _____

Who works with your child at school?

Principal: _____ Counselor/Social Worker: _____
Classroom Teacher: _____ Teacher's Assistant: _____
Child's Aide: _____ Speech Therapist: _____
Occupational Therapist: _____ Special Education Teacher: _____
Other: _____ Other: _____

Reason for Seeking Services

Does your child have a diagnosis? Y N

If yes, what is the current diagnosis? _____

Date diagnosed: _____ Age at diagnosis: _____ Diagnosed by: _____

Was this diagnosis firm or questionable? _____

Why are you seeking services from us?

What are your goals and expectations from us?

Please list your child's previous and current services:

Service 1:

Type of Treatment: _____

Service Provider: _____

Duration of Treatment: _____

Service 2:

Type of Treatment: _____

Service Provider: _____

Duration of Treatment: _____

Service 3:

Type of Treatment: _____

Service Provider: _____

Duration of Treatment: _____

Service 4:

Type of Treatment: _____

Service Provider: _____

Duration of Treatment: _____

Goals and Objectives:

Please list some goals that you would like your son/daughter to achieve:

Please fill out your child's current schedule:

	MON	TUES	WEDS	THURS	FRI	SAT	SUN
7:00 AM							
8:00							
9:00							
10:00							
11:00							
12:00 PM							
1:00							
2:00							
3:00							
4:00							
5:00							
6:00							
7:00							

Where did you learn about Consultants for Children, Inc.? _____

Is there other additional information you would like us to know about your child/family? _____

Intake completed by: _____ Date: _____