Debra Kessler, Psy.D., R.N., M.N.
Specializing in children with emotional & developmental challenges
Clinical Psychologist, LIC. 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?

_____

How soon after birth did mother return to work? _____

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	☐ Lisping
☐ 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 activites:	
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:

_____
_____
_____

My child's strengths are:

_____
_____
_____

The most challenging aspect for me of parenting my child is:

_____
_____
_____

Things my child and I enjoy doing together:

_____
_____
_____

My goals for treatment for my child are:

_____
_____
_____

Please use this space to provide any other information that you think might be helpful.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____