Dear Family,

Phenix City Children's is proud to offer a variety of psychological services, including comprehensive evaluations and intervention services. In order to best meet your needs we need as much information as we can get from you. In addition to the attached form, we need copies of any previous testing that has been completed (e.g., school testing, speech testing, etc.) and any IEP documents that you may have. Please mail all documents or drop them by our office:

Phenix City Children's
3700 A South Railroad St.
Phenix City, AL 36867

As soon as we receive your form, we will schedule your initial appointment with the psychologist. If you have any questions, please contact us at (334)664-0463. We look forward to hearing from you!

Date: _____

Phenix City Children's

Child Intake Form for Psychologist

Basic Demographic, Background, and Contact Information

Child's Name	Child's Date of Birth	Child's Age	Child's Sex ❑ Male ❑Female
Mother's name	Father's name		
Who has legal custody of this child (if different from above)?	Who does the child live with (if different from above)?		
Name of person completing this form:	Relationship to the child:		
May we leave a message on your answering machine or voicemail? ❑ Yes ❑ No	May we identify our clinic and the doctor's name when we call? ❑ Yes ❑ No		

Referral Source

Who referred you to the psychologist?	
Phone	How do you know this person? ❑ Physician ❑ Through Work ❑ Relative ❑ Friend/Acquaintance ❑ School Personnel ❑ Other: _____
May we contact this person/agency for more information about their concerns? ❑ YES ❑ NO _____Please Initial here	
May we contact this person/agency to let them know that you have scheduled an appointment with the psychologist? ❑ YES ❑ NO _____Please Initial here	

Referral Concerns

What type of services are you requesting for your child at this time? ❑ Evaluation/Testing ❑ Therapy
Why are you requesting services for your child at this time?

Do you have concerns about your child in any of the following areas? If so, please check the box and describe.

	Check all that apply	*Description*
Aggression		
Alcohol/drug use		
Anxiety/Worry/Fears		
Attention/Distractibility		
Dangerous behaviors		
Depression		
Hyperactivity		
Language/Conversation Skills		
Learning Problems		
Social Interaction		
Other concerns		

Intervention History

Has your child ever been in therapy or had a psychological/learning evaluation before? ❑ YES ❑ NO
If yes, please describe, including dates.
Has your child ever been hospitalized for behavior or mental health reasons? ❑ YES ❑ NO
If yes, please describe, including dates.
Has your child been given any previous diagnoses? ❑ YES ❑ NO

If yes, please check the box next to all that apply.

	Check all that apply		***Check all that apply***
Anxiety Disorder		Attention Deficit Hyperactivity Disorder (ADHD)	
Autism Spectrum Disorder (e.g., Autism, Asperger's Syndrome, Pervasive Developmental Disorder)		Depression or other mood disorder	
Learning Disability		Mental Retardation/Intellectual Disability	
Oppositional Defiant Disorder		Other (Specify)	

Pregnancy, Birth and Developmental History

While pregnant with this child, did mother experience: If so, please check the box and describe.

	Check all that apply	***Description***
Bleeding		
Infections		
High blood pressure		
Toxemia		
Anemia		
Preterm labor		
Other complications, hospitalizations, or problems during pregnancy		
Smoke		If yes, how many packs/week?
Alcohol		If yes, how many drinks/week?
Drugs		
Severe emotional stress		

Birth History

Birth weight: _____(pounds) _____(ounces)	Was baby premature? ❑ YES ❑ NO If yes: _____(weeks)		
Type of labor: ❑ Vaginal ❑ Caesarian	Length of labor _____(hours)	Was labor spontaneous or induced? ❑ Spontaneous ❑ Induced	Were forceps used? ❑ YES ❑ NO
Was the cord around the neck? ❑ YES ❑ NO		Did the baby have difficulty breathing? ❑ YES ❑ NO	
Was baby jaundiced? ❑ YES ❑ NO	If yes, was the baby treated with phototherapy (lights)? ❑ YES ❑ NO If yes, how long? _____ hours		
Was there meconium in the amniotic fluid? ❑ YES ❑ NO	Did the baby have to stay in an incubator? ❑ YES ❑ NO If yes, how long? _____ hours		
Were there any other problems with the baby at birth? ❑ YES ❑ NO If yes, describe:	Other problems in the newborn period:		

Medical History

Has your child experienced problems with any of the following? If so, please check the box and describe, including age.

	Check all that apply	**Age (years)**		***Check all that apply***	**Age (years)**		***Check all that apply***	**Age (years)**
Allergies			Fainting spells			Reflux		
Apnea (holding breath when asleep)			Frequent falls			Snoring		
Asthma			Head injury			Spina bifida		
Broken bones			Headaches and/or migraines			Staring spells		
Cerebral palsy			Hearing impairment or deafness			Frequent stomach pain		
Colic			Heart problems			Swallowing problems		
Constipation			Meningitis and/or encephalitis			Tics or twitches		
Convulsions and/or seizures			Obesity			Unconsciousness		
Diabetes			Pneumonia			Vision problems or blindness		
Frequent diarrhea			Poisoning			Weight loss or poor weight gain		
Hospitalizations *Please explain*		***Explanation:***						
Surgery *Please explain*		***Explanation:***						
Other chronic medical problems or concerns (Specify)		***Explanation:***						

Medication History

Please complete the chart below for current medications:

Name of Current Medications	Current Dosage	When Began this Medication?	Reason for Medication

Family Tree

If any of the child's biological relatives have had any of the following conditions, please check the box next to the condition and write that person's relationship to the child (e.g., aunt – father's side) next to it. By relatives, we mean biological parents, brothers, sisters, grandparents, aunts, uncles, and cousins on both sides.

Condition	***Check all that apply***	**Relationship to Child** (e.g., grandmother – mother's side)	**Condition**	***Check all that apply***	**Relationship to Child** (e.g., grandmother – mother's side)
Alcohol/Drug abuse			Convulsions, seizures, epilepsy		
Anxiety Disorders: Generalized Anxiety Disorder			Emotional Disturbance		
Obsessive Compulsive Disorder			Learning/reading disability		
Panic Disorder			*Mood Disorders:* Depression		
Social Phobia			Bipolar (Manic-Depressive) Disorder		
Other Anxiety Disorder			Schizophrenia		
Attention-Deficit/ Hyperactivity Disorder (ADHD)			Slow Development/Mental Retardation/Intellectual Disability		
Autism Spectrum Disorders: Autism			Speech/Language Disorder		
Asperger's Syndrome			Suicide		
Pervasive Developmental Disorder,Not Otherwise Specified (PDD-NOS)			Tourette's Disorder/Tics		
Cerebral palsy			Other (Specify):_____		

Please print the name of person completing form:	
Signature	**Date**