PEDIATRIC PSYCHOLOGICAL ASSOCIATES, PLLC
9700 Park Plaza Avenue, Suite 106
Louisville, KY 40241
Phone: (502) 429-5431
Fax: (502) 429-5439
www.helpingkidsreachhigher.com

INTAKE QUESTIONAIRRE	
BASIC INFORMATION	
Legal Name of Person Completing this Form:	
Date Completed:	Relationship to Child:
How did you hear about our practice?	

CHILD'S IDENTIFYING INFORMATION		
Legal Name of Child/Teen:		
Date of birth:	Current Age:	Gender: □ Male □ Female
Race/Ethnicity:		
Marital Status of the Child's Biological or Adoptive Parents: □ Married, when _____ □ Divorced, when _____ □ Separated, when _____ □ Live with partner, when _____ □ Other – Please Describe :_____	*If divorced, does the other parent have:* □ Sole Custody □ Shared or Joint Custody □ Visitation □ Supervised Visitation □ No Visitation Rights □ Other – Please Describe: _____	
If parents are divorced: Is there current pending legal action related to divorce/custody? □ Yes □ No If yes, please describe: _____ Are you aware of any upcoming legal action? □ Yes □ No If yes, please describe: _____ How would you describe your current ability to co-parent with your ex-spouse? _____ ******If joint or shared custody, both parents must agree and consent for treatment in writing unless legal documentation is provided.******		

Preferred 1-2 phone number(s) for courtesy reminder calls:

Phone 1:	OK to leave a message: □ Yes □ No
Phone 2:	OK to leave a message: □ Yes □ No
Preferred e-mail address:	

BILLING DATA		
Name of Insured (The person who is the policy holder):		
Insured's relationship to patient:		
Street Address:		
City:	State:	Zip:
DOB of Insured:	SSN of Insured:	
Insured's Employer:		
Insurance Carrier:		
Phone # on Insurance Card (Mental Health if specified):		
Identification Number of Child:	Group Number:	

Account Responsible/Guarantor (Person who will pay balance after insurance pays:		
□ Check if same as Insured		
Name of Guarantor:		
Guarantor's relationship to patient:		
Street Address:		
City:	State:	Zip:
DOB of Guarantor:	SSN of Guarantor:	

FAMILY INFORMATION	
Full Legal Name of Parent 1 (Biological/Adoptive Parent):	
DOB:	Highest grade completed:
Occupation:	Place of Employment:
Home Phone:	OK to leave a message on home: □ Yes □ No
Cell Phone:	OK to leave a message on cell: □ Yes □ No
E-mail Address:	
OK to e-mail (please note that e-mail is not a secure form of communication): □ Yes □ No	

Full Legal Name of Parent 2 (Biological/Adoptive Parent):	
DOB:	Highest grade completed:
Occupation:	Place of Employment:
Home Phone:	OK to leave a message on home: □ Yes □ No
Cell Phone:	OK to leave a message on cell: □ Yes □ No
E-mail Address:	
OK to e-mail (please note that e-mail is not a secure form of communication): □ Yes □ No	

Full Legal Name of Step-parent 1 (if applicable):	
DOB:	Highest grade completed:
Occupation:	Place of Employment:
Home Phone:	OK to leave a message on home: □ Yes □ No
Cell Phone:	OK to leave a message on cell: □ Yes □ No
E-mail Address:	
OK to e-mail (please note that e-mail is not a secure form of communication): □ Yes □ No	

Full Legal Name of Step-parent 2 (if applicable):	
DOB:	Highest grade completed:
Occupation:	Place of Employment:
Home Phone:	OK to leave a message on home: □ Yes □ No
Cell Phone:	OK to leave a message on cell: □ Yes □ No
E-mail Address:	
OK to e-mail (please note that e-mail is not a secure form of communication): □ Yes □ No	

Full Name of Legal Guardian (if applicable):
Is there a legal guardian other than a parent involved? □ Yes □ No
If YES, please describe:

Adoption (if applicable) : Is your child adopted? □ Yes □ No
If YES, please include age of child at adoption and any information known about biological parents:

Name of Emergency Contact (other than parent):
Relationship to Child:
Emergency Contact Phone Number:

Sibling Information (full, half, step, living, or deceased):

Name	Age	Sex	Grade	Relationship to child?	Living with child?

Family Medical History:
Family Mental Health History:

REASON FOR SEEKING TREATMENT
Please briefly describe the problems your child is experiencing:
What do you consider to be other stressors in your child's life?
What made you seek help at this time?
What do you hope to be able to do or achieve as a result of treatment?

HISTORY OF THE CURRENT PROBLEM	
When did your child first start experiencing the problem(s) that have led you to seek treatment?	
Has your child ever had any thoughts of harming him/herself or others? □ Yes □ No If YES, please explain:	
Has your child ever attempted to harm him/herself or others? □ Yes □ No If YES, please explain:	
Has your child ever engaged in any self-harm behavior (e.g., cutting, scratching, burning, etc.)? □ Yes □ No If YES, please explain:	
Has your child ever had previous therapy/counseling of any kind? □ Yes □ No If YES, Name of Provider:	
When:	For how long?
What concerns were addressed?	
Was the experience helpful (please explain)?	
Has your child even been hospitalized for emotional/behavioral problems? □ Yes □ No If YES, please explain and include dates:	

CHILD'S EARLY HISTORY			
PREGNANCY & DELIVERY			
Did biological and/or birth mother use any of the following during pregnancy?			
Substance	Yes	No	How often?
Tobacco			
Alcohol			
Other Drugs (please list):			

Mother's prescribed medication during pregnancy		
Medication	When	Reason

Age of Biological Mother at Delivery:	Age of Biological Father at Delivery:
Describe any difficulties during pregnancy:	
Length of Pregnancy:	Birth Weight:
Describe any difficulties during delivery:	
Any medical problems noted at or immediately following birth? □ Yes □ No If YES, please note:	

CHILD'S EARLY DEVELOPMENT	
Please note the age at which your child reached the following motor AND language milestones. If you don't remember the exact age, give an approximate age.	
Motor	**Language/Communication**
1. Sit alone:	5. Respond to simple spoken requests:
2. Crawl:	6. Use simple gestures (e.g., shaking head "no," waving "bye-bye," etc.):
3. Stand alone:	7. Started speaking single words (not including "mama/dada"):
4. Walk alone:	8. Started speaking 3 word-sentences:

Was your child ever evaluated for or did he/she receive any First Steps or other early intervention services? □ Yes □ No If YES, please describe:
Has your child ever received speech therapy? □ Yes □ No If YES, please describe:
Has your child ever received occupational therapy? □ Yes □ No If YES, please describe:

Please note any difficulties your child has experienced with the following:			
	Never	In the Past	Currently
Toileting			
Eating			
Sleeping			
Sensory			
Vision			
Hearing			
If Hearing or Vision, please explain:			

If you are bringing your pre-teen or teen to the office, are you aware of their use of the following:			
	YES	NO	Not that I am aware of
Tobacco			
Alcohol			
Other Drugs (please list):			

MEDICAL HISTORY OF CHILD			
Name of your child's pediatrician/primary care doctor:			
Pediatric Group Practice Name:			
Phone Number:		Fax Number:	
Child's current:	Height:	Weight:	Or percentiles:

Describe any serious accident, illness, or injury which your child has experienced:	Age:
Has your child ever had a high fever above 104 degrees? □ Yes □ No If YES, please explain and include how long the high fever lasted:	

Has your child ever lost consciousness (e.g., brain injury, accident, fainting)? □ Yes □ No If YES, please explain:
Does your child have a history of seizures? □ Yes □ No If YES, please explain:
Please list any allergies (environmental, food, medication, other) that your child has:

Please list any surgeries that your child has undergone:	
Surgery:	When:

Current Medication	Dose/Frequency	When started (Date)	Who prescribes the medication?

EDUCATIONAL & SOCIAL HISTORY OF THE CHILD
Attended pre-school? □ Yes □ No
Attended kindergarten? □ Yes □ No
Participation in resource, special education, or gifted program? □ Yes □ No If YES, What type of classes/services?
Does your child have a 504 or Individualized Education Plan (IEP)? □ Yes □ No
Ever had psychological/psychoeducational testing at school or elsewhere? □ Yes □ No If YES, Please describe:
Ever repeated a grade? □ Yes □ No If YES, Please describe:
Ever been encouraged to leave, suspended or expelled? □ Yes □ No If YES, what grade and why:

Name of Current School:	
Grade:	Name of Primary Teacher:
What are your child's typical grades:	
Hardest Subject(s):	Favorite subject(s):

Describe any academic difficulties that your child is currently having in school:
Describe any social difficulties your child has experienced:
Any family history of academic or learning problems?

STRENGTH & ASSETS OF THE CHILD & FAMILY
What are your child's hobbies and interests?
Are they involved in any extracurricular activities or clubs? □ Yes □ No If YES, please describe:
What are your child's strengths and positive characteristics?
What are your family's strengths?

Please use the space below to note anything else you feel the psychologist should know in helping your child.