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Today's Date:_____

Child Name: _____ **DOB:** _____

School: _____ **Grade:** _____

Referred by: _____

Parent/Guardian 1:_____

Home Address: _____

_____

(H) Phone: _____ **(C) Phone:** _____

(W) Phone: _____ **Email:** _____

***Please indicate the best number to reach you at or best way to contact you**

May I leave a message identifying who I am? Yes No

Occupation:_____

Employer: _____

Parent/Guardian 2:_____

Home Address: _____

_____

(H) Phone: _____ **(C) Phone:** _____

(W) Phone: _____ **Email:** _____

***Please indicate the best number to reach you at or best way to contact you**

May I leave a message identifying who I am? Yes No

Occupation:_____

Employer: _____

Are you and your child's other parent:

Married to each other? Y / N If so, how long? _____

Living together but not married? Y / N If so, how long? _____

Divorced or Separated from each other? Y / N If so, how long? _____

How long were you married before you were divorced/separated? _____

IF YOU AND YOUR CHILD'S OTHER PARENT ARE DIVORCED OR SEPARATED, PLEASE EXPLAIN <u>CUSTODY*</u> AND <u>VISITATION</u> ARRANGEMENTS PER COURT AGREEMENT. (If a court agreement does not exist, please write so).

***PLEASE NOTE THAT IF YOU AND YOUR CHILD'S OTHER PARENT ARE DIVORCED/ SEPARATED AND HAVE *JOINT CUSTODY*, THEN BOTH PARENTS MUST SIGN THE "PERMISSION TO TREAT" FORM IN ORDER FOR THERAPY TO BEGIN.**

***PLEASE NOTE THAT A COPY OF THE DIVORCE / SEPARATION AGREEMENT WILL BE REQUIRED FOR YOUR CHILD'S CHART IN ORDER FOR THERAPY TO BEGIN.**

Who should be notified in case of emergency? (Please provide someone other than yourself and the child's other parent).

Name: _____

Relationship: _____

(H) Phone: _____ **(C) Phone:** _____

(W) Phone: _____ **Email:** _____

Child's Siblings: Please specify step-siblings and half-siblings if necessary.

NAME	SIBLING	AGE
_____	Brother / Sister	_____
_____	Brother / Sister	_____
_____	Brother / Sister	_____
_____	Brother / Sister	_____

Pediatrician Name: _____

Phone: _____

Is your/the child on any medications? (Please include any over-the-counter medication that is used regularly). Y / N

NAME	DOSEAGE	FREQUENCY	REASON
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your child ever been seen by a mental health professional in the past? Y / N **If yes, please indicate who, when and why:**

DEVELOPMENTAL DATA

Was child adopted? Y / N

If so, please fill in as much information as possible.

Length of gestation: _____ (months)

Did your child experience and complications during gestation? Y / N

If yes, please explain:

Did mother experience any complications during pregnancy? Y / N

If yes, please explain:

Was this a planned pregnancy? Y / N

Were any special means used to conceive (such as hormone treatment, etc.)? Y / N

If yes, please explain:

Did mother use any medications regularly during pregnancy? If so,

NAME	DOSEAGE	FREQUENCY	REASON
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Length of labor: _____ (hours)

Did your child experience and complications during mother's labor/delivery? Y / N

If yes, please explain:

Did mother experience any complications during labor/delivery? Y / N

If yes, please explain, including type of delivery:

Did mother use any medications during labor/delivery? Y / N

Please list:

Length of hospital stay: _____ (days)

Did your child experience and complications after the birth? Y / N

If yes, please explain:

Weight at birth: _____ Length at birth: _____

Were there any complications with <u>feeding</u>? Y / N

Was your child:

1. **Exclusively breast- fed? Y / N (if so, for how long?_____)**
2. **Exclusively formula fed? Y / N (if so, for how long? _____)**
3. **Mixed formula and breast fed? Y/N**

Did/Does your child have any complications with <u>sleeping</u>? Y / N

If so, please explain?

At what age was your child able to sleep through the night? _____

Did/Does your child have any complications with <u>potty training</u>? Y / N

If so, please explain?

At what age was your child when he/she obtained bladder control? _____

At what age was your child when he/she obtained bowel control? _____

Did/Does your child have any complications with motor development?

If so, please explain?

Do you/did you have any concerns about your child's language development?

If so, please explain?

Does your child exhibit any sensory sensitivity? (Visual, tactile, auditory)

For instance, does he/she complain that some environments get "too loud?" Y / N

Or that some foods "feel funny" in their mouths? Y / N

Or that temped bath water is "too hot?" Y / N

Does he/she retreat from rooms with walls covered in a lot of art/posters/etc? Y / N

If "yes," please explain?

FAMILY HISTORY

Does anyone in the family have a history of medical illness? If yes, please explain:

Does anyone in the family have a history of psychiatric illness? If so, please explain?

Does anyone in the family have a history of trauma? If so, please explain.

Is there anything else you think is important for me to know about your child? Y / N

If so, please explain?

THANK YOU FOR COMPLETING THIS LENGHTY QUESTIONNAIRE