The Oak Inside Intake-Child

1. **Please enter your information.**

First Name: ______ Middle Initials: ______ Last Name: ______ Date of Birth: ______

Gender: ◌ Female ◌ Male
Age: ______
Ethnicity: ______

Address: ______ Apt./Unit #: ______

Mobile Phone: ______
Consent to leave a detailed voice message here? ◌ Yes ◌ No
Home Phone: ______
Consent to leave a detailed voice message here? ◌ Yes ◌ No

Consent to send text appointment reminders here? ◌ Yes ◌ No
Primary Email: ______
Consent to send email appointment reminders? ◌ Yes ◌ No

School: ______ Grade: ______

Person completing this form: ______ Relationship to child: ______

2. **Marital status of parents:**

◌ Married
◌ Separated
◌ Divorced
◌ Single
◌ Other

If other, please specify:

______

3. **Child lives with:**

◌ Both Parents
◌ Mother
◌ Father
◌ Other

4. If separated or divorced, how old was the child when separation occurred?

______

If remarried, how old was the child when the stepparent entered the family?

______

***If child's parents are divorced, who has legal custody or primary conservatorship and/or has the right to consent to psychological services)?

______

5. **Biological Mother**

Name: ______________________ Age: __________

Highest level of Education ______________ Occupation: ______________

Dominant language spoken in home: ______________ Other languages spoken in the home: ______________

6. **Biological Father**

Name: ______________________ Age: __________

Highest level of Education ______________ Occupation: ______________

Dominant language spoken in home: ______________ Other languages spoken in the home: ______________

7. **Was your child adopted?**

- Yes
- No

8. **If yes:**

What age was child first in the home? ______________ Date of legal adoption? ______________

What has your child been told about adoption? ______________

9. **List all people living in the household with the child:**

	Name	Age	Male	Female	Relationship to Child:
1					
2					
3					

10. **List any siblings or other immediate family members living outside the home:**

	Name	Age	Male	Female	Relationship to Child:
1					
2					
3					

11. **Please check all that apply for the last 12 months:**

- ☐ family moved
- ☐ repeat a grade
- ☐ new baby at home
- ☐ family financial problems
- ☐ conflict in family
- ☐ parent changed job
- ☐ history of abuse
- ☐ family accident or illness
- ☐ changed school
- ☐ death in family
- ☐ parents separated/divorced
- ☐ other

If other, please specify:

____

12. **Please add any comments regarding the items noted above:**

____

____

____

____

REFERRAL INFORMATION

13. **How did you find us?**

- ☐ Google Search
- ☐ Autism Speaks Website
- ☐ Referred by professional
- ☐ Psychology Today
- ☐ Another website
- ☐ Other
- ☐ www.drjaquiotto.com
- ☐ Referred by Friend

If other, please specify:

____

14. **If Another website, what website:**

____

15. **If Referred by professional, please provide details:**

____

16. Briefly describe your child's current difficulties:

____

____

How long has it been a concern? ______________ When did this concern arise? ______________

What seems to make the problem better?

____

What seems to make it worse?

____

What do you believe to be the major cause of the problem(s)?

____

Do both parents agree about the nature and cause of the difficulties?

____

PREVIOUS INTERVENTION/ SERVICES

17. Please check all your child has received or is currently receiving:

- ☐ Psychoeducational testing
- ☐ Speech-language evaluation
- ☐ Occupational/physical evaluation
- ☐ Neurological evaluation
- ☐ Genetic testing
- ☐ MRI/EEG
- ☐ Neuropsychological evaluation
- ☐ Psychiatric evaluation
- ☐ ABA therapy
- ☐ Social skills intervention
- ☐ Counseling/therapy
- ☐ Family therapy/Parenting classes
- ☐ Speech/Language therapy
- ☐ Occupational/Physical therapy
- ☐ Other

If other, please specify:

____

18. Please provide information regarding where and when these services occurred. **BRING COPIES OF REPORTS TO INTAKE SESSION

____
____
____
____

19. Is your child being treated for any medical illness?

- ○ Yes
- ○ No

20. If yes, what condition(s) is your child being treated for?

____
____
____
____

21. Is there a history of self-harm or suicidal thoughts, threats, or attempts? Please explain:

____
____

List any previous or current mental health diagnoses:

____
____

22. Does your child regularly take over the counter or prescription medication?

- ○ Yes
- ○ No

23.

	Medication	Dosage	Reason
1			
2			
3			

24. Describe your child's response to medications (positive and negative effects):

List any medications your child has taken in past, dosage, and reason for medications:

PRENATAL HISTORY

25. Check the items below that occurred during pregnancy:

- ☐ Edema (swelling)
- ☐ Toxemia
- ☐ Alcohol used
- ☐ Recreational drugs used
- ☐ Hospitalization
- ☐ Breathing difficulties
- ☐ Infections
- ☐ Pre-term labor
- ☐ Vaginal bleeding
- ☐ High blood pressure
- ☐ Abnormal weight gain
- ☐ Accidents / Injuries
- ☐ Emotional stress
- ☐ Cigarettes used
- ☐ Other

If other, please specify:

26. Please explain all "yes" answers:

BIRTH HISTORY

27. Was the baby on time?
○ Yes ○ No

If no, how early/late was birth?

Birth Weight:

Mother's age at birth:

Father's age at birth:

28. Check all that apply:

- ☐ Spontaneous labor
- ☐ C-section
- ☐ Vaginal delivery
- ☐ Breech presentation
- ☐ Induced labor
- ☐ VBAC (vaginal birth after C-section)

29. **If C-section, planned?**

- ○ Yes
- ○ No

30. **Please add any comments regarding the items noted above:**

____

____

____

____

POST-DELIVERY PERIOD

31. How many days did the baby stay in the hospital after birth?

____

Was neonatal care needed? If yes, what kind and how long?

____

32. **Please check items below that occurred during child's birth:**

- ☐ Infection
- ☐ Water on the brain
- ☐ Poor feeding
- ☐ Jaundice
- ☐ Turned blue
- ☐ Need for ventilation
- ☐ Fever
- ☐ Bleeding in head
- ☐ Blood transfusion
- ☐ Other
- ☐ Vomiting / Reflux
- ☐ Difficulty breathing
- ☐ Neonatal ICU (NICU)
- ☐ Floppy muscle tone

If other, please specify:

____

33. **Please explain all checked items:**

____

____

____

____

INFANCY/TEMPERMENT

34. **Check items below that occurred during the first few years of life:**

- ☐ Difficult to comfort
- ☐ Excessive irritability
- ☐ Extremely passive
- ☐ Difficulty feeding
- ☐ Sleep difficulties
- ☐ Excessive restlessness
- ☐ Frequent head banging
- ☐ Enjoyed Cuddling

35. **Please explain all "yes" answers:**

____

____

____

____

DEVELOPMENTAL MILESTONES

Please complete the chart below regarding your child's mastery of early developmental milestones:

36. At what age did your child first do the following?

	Age
Smile	
Crawl	
First Words	
Roll Over	
Walk Alone	
Put two or more words together	
Sit Alone	
Walk Upstairs	
Toilet trained for day	
Toilet trained for night	

37. Did bed wetting or soiling occur after training?
- Wetting
- Soiling

If yes, until what age?

Does your child have speech difficulties?

Motor difficulties? (i.e., clumsy, poor fine motor or gross motor coordination)

HEALTH HISTORY

38. Please check the items that your child has experienced:

- Vision problems
- Sleep problems
- Head injury
- Tremors
- Concussion
- Bed wetting
- Hearing Problems
- Frequent falls
- Other
- Loss of consciousness
- Stool soiling
- Coma
- Anemia
- Asthma
- Chronic ear infections
- Allergies
- Persistent high fever
- Seizures
- Hospitalization
- Tics
- Headaches
- Stomach aches
- Surgery
- Staring spells
- Broken bones/ stitches

If other, please specify:

39. Please explain all "yes" answers:

40. Last vision exam date: Results:

Last hearing exam date Results:

41. Describe your child's sleep routine:

Typical bedtime: Typical wake time: Trouble falling asleep: ○ Yes ○ No

Trouble staying asleep: ○ Yes ○ No

Wakes up early: ○ Yes ○ No

Any other sleep problems?

42. Describe your child's diet:

Describe your child's current level and types of exercise:

43. Have any family members been identified with the following condition(s): Condition: Family Member (in relation to child)

	Yes	Family Member
Learning Problems		
Depression or sadness		
Anxiety Disorder		
Autism Spectrum Disorder		
Suicide/Suicide attempt		
Tourette Syndrome		
Dyslexia		
Alcoholism/Drug Abuse		
Bipolar Disorde		
Attention Deficits		
Schizophrenia		
Cognitive Impairment		

EDUCATIONAL HISTORY

44. **Does your child attend school?**

 - ○ Yes
 - ○ No

45. **Did your child attend preschool?**

 - ○ Yes
 - ○ No

46. **If yes:**

What age? ____________________ Name of preschool: ____________________

Were there adjustment problems in preschool?
○ Yes ○ No
If yes, explain: ____________________

Were you concerned about your child's success in preschool?
○ Yes ○ No
If yes, explain: ____________________

Did your child receive services through ECI or PPCD?
○ Yes ○ No
If yes, explain: ____________________

SCHOOL HISTORY

47. **ELEMENTARY**

	Schools Attended	Grades your child attended there	Any special services or interventions provided
1			
2			
3			

48. **INTERMEDIATE/MIDDLE**

	Schools Attended	Grades your child attended there	Any special services or interventions provided
1			
2			
3			

49. HIGH SCHOOL

	Schools Attended	Grades your child attended there	Any special services or interventions provided
1			
2			
3			

50. Address of current school: ______________________ Telephone: ______________

Teacher: ______________________ Grade: ______________

51. Current Class placement: (Check all that apply)

- ☐ Regular class
- ☐ ESL
- ☐ Bilingual
- ☐ Gifted & Talented
- ☐ Special class

If special class, please specify:

____

52. What type of grades does your child typically receive?

____

Do you feel your child is performing at the same academic level as his/her peers

____

Does your child currently receive educational interventions or modifications (e.g., extended time on assignments, distraction free environment for testing, resource room, etc.)?

____

53. Does your child have a 504 Plan at school?

- ○ Yes
- ○ No

54.If yes, **please bring a copy with you to your appointment .**

55. Does your child have an IEP at school?

- ○ Yes
- ○ No

56.If yes, **please bring a copy with you to your appointment .**

57. How does your child perform on state testing (STAAR)?

____

Are you satisfied with your child's educational program?

____

How often is your child absent from school?
○ Never ○ Often ○ Seldom

Usual reason for absence: ____________________

58. **Has your child ever been retained?**

○ Yes
○ No

59. **If yes:**

What grade? ____________________

Why? ____________________

60. **Has your child ever been:**

	Yes	No	iIf yes, how many times?
Suspended			
Expelled			

HOME LIFE

61. What are your child's favorite activities?

What are your child's least favorite activities?

How often must you discipline your child

What forms of discipline are used?

What have you found to be the most effective form of discipline?

Describe your child's typical mood:

What about your child makes you proud?

62. How does your child get along with his/her peers?
○ Great ○ Good ○ Fair ○ Poor

How does your child get along with his/her siblings?
○ Great ○ Good ○ Fair ○ Poor

Does your child have any close friends?
○ Yes ○ No

If yes, how many? ____________________

Does your child get along best with:
☐ older children ☐ same age children
☐ younger children

63. **Has your child experienced any of the following:**

	Yes	No
Past or present exposure to domestic violence?		
Past or present Abuse or neglect?		
Involvement with Department of Family Services?		

64. **Please explain any 'Yes' responses:**

____

____

____

____

CHARACTERISTICS/SYMPTOMS

Please check those behaviors that your child exhibits to an excessive or exaggerated degree compared with other children his/her age.

65. **Speech and Language:**

- ☐ Difficulty listening to verbal information
- ☐ Confuses speech sounds
- ☐ Mispronounces words
- ☐ Jumbles up sounds in words
- ☐ Speaks in a monotone or exaggerated manner
- ☐ Misunderstands verbal directions
- ☐ Misunderstands Jokes, sarcasm, or idioms
- ☐ Exhibits slow or halting speech
- ☐ Difficulty expressing thoughts clearly
- ☐ Speaks only to family members

66. **Comments on questions above:**

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____

____

____

67. **Behavior:**

- ☐ Self-injurious behavior: head banging or hair pulling
- ☐ Cries easily
- ☐ Appears sad or irritable
- ☐ Disinterested in participating in activities
- ☐ Low frustration tolerance
- ☐ Insists upon doing things a certain way
- ☐ Difficulty making transitions
- ☐ Lines up his/her toys
- ☐ Sensitive to certain sounds
- ☐ Sets fires
- ☐ Dislikes being touched
- ☐ Engages in inappropriate sexual behavior
- ☐ Suspicious of others
- ☐ Self-injurious behavior: cutting
- ☐ Runs away
- ☐ Emotional outbursts
- ☐ Physical aggression toward others or objects
- ☐ Sudden mood changes
- ☐ Makes excessive physical complaints
- ☐ Avoids going to school
- ☐ Compulsive or ritualistic behavior(s)
- ☐ Repetitive movements: rocking or hand flapping
- ☐ Shows aversions to textures
- ☐ Steals from others
- ☐ Alcohol or drug use
- ☐ Engages in socially inappropriate behavior
- ☐ Displays odd movements or habits
- ☐ Socially isolates and withdraws from others
- ☐ Sexual activity, behavior, or sexual talk
- ☐ Argues with adults

68. **Comments on questions above:**

____
____
____
____

69. **If Sensitive to certain sounds, please list:**

____
____
____
____

70. **If Shows aversions to textures, please list:**

____
____
____
____

71. **Social Skills:**

- ☐ Trouble conversing with others
- ☐ Difficulty making eye contact
- ☐ Trouble making and or maintaining friendships
- ☐ Overly trusting of others
- ☐ Excessively shy or timid
- ☐ Doesn't understand the body language of others
- ☐ Doesn't understand other's beliefs or intentions
- ☐ More interested in objects than peopl
- ☐ Teased/bullied by others
- ☐ Other

If other, please specify:

____

72. **Comments on questions above:**

____

____

____

____

73. **Attention:**

- ☐ Often tired during the day
- ☐ Difficulty beginning or completing work
- ☐ Easily distracted
- ☐ Difficulty remembering recently learned info.
- ☐ Difficulty concentrating
- ☐ Miss parts of explanations and directions
- ☐ Difficulty learning from mistakes/errors
- ☐ Has a messy room
- ☐ Frequently procrastinates
- ☐ Doesn't write down/keep track of assignments
- ☐ Difficulty planning for projects/tests?
- ☐ Difficulty completing work/tasks in a reasonable amount of time?
- ☐ Inconsistent attention and focus
- ☐ Perform inconsistently in school
- ☐ Need instructions repeated
- ☐ Daydreams frequently
- ☐ Act without thinking
- ☐ Difficulty staying on task
- ☐ Trouble learning from consequences/rewards
- ☐ Has a messy backpack or locker
- ☐ Frequently lose personal items
- ☐ Loses or forgets to turn in completed work
- ☐ Has difficulty prioritizing work
- ☐ Other

74. **Comments on the questions above:**

____

____

____

____

75. **Learning: Does/Did your child have trouble learning any of the following:**

- ☐ The alphabet
- ☐ Reading fast enough
- ☐ Knowing how to study for a test
- ☐ Understanding what he/she reads
- ☐ Remembering instructions for an assignment
- ☐ Telling time
- ☐ Performing math calculations
- ☐ Days of the week/months of the yea
- ☐ Writing neatly
- ☐ Managing homework
- ☐ Spelling accurately
- ☐ Writing a paper or report
- ☐ Sounding out words
- ☐ Understanding math word problems

76. **Comments on questions above:**

____
____
____
____

ADDITIONAL INFORMATION

Thank you for taking the time to fill out this questionnaire. The more details I know about your child the better I can understand your child's needs and find solutions that will be helpful.

77. **Please add any additional information you think is relevant or that you would like me to know:**

____
____
____
____

Please bring copies of any evaluations, report cards, results of state testing, and 504 or IEP meeting notes with you to our initial meeting.

Person Completing Questionnaire

____
Signature