CHILD INTAKE

Child's Name: ____________________________________Date of Birth: ____________

Home Address: ____

City: _______________________________ State: ___________ Zip: _____________

Home Phone Number: (____)________________

Form completed by: _________________________ relationship to child _____________

Child's Physician: ___________________________ Phone: ______________________
Clinic: ____

Parent Information:
Are the child's parents: Married Separated Divorced How long? __________

Father: ____
Address if different from above: ___________________________________
City: _________________________ State: ___________ Zip: _____________
Home Phone: (_____)________________ Work: (____)________________
Occupation: ____
If divorced, is father remarried or in a significant relationship? _______________

Mother: ____
Address if different from above: ___________________________________
City: ________________________ State: ___________ Zip: _____________
Home Phone: (_____)________________ Work: (____)________________
Occupation: ____
If divorced, is mother remarried or in a significant relationship? ______________

Insurance information

Person responsible for payment: ____
Insurance Company: __________________________ Policy # ______________________
Policy Holder: ______________________________ Group/Account #: _______________
Policy Holders relationship to child: ____

Child Information

School Attending: ______________________________________ Grade: ___________
Teacher: ______________________City of School: _____________________________
Child's favorite subject: ____
Extra-curricular activities: ____
____
____

Siblings (star any that are stepsiblings)

Name ____________________________ Age ________ Residence: Mom Dad Both Other
Name ____________________________ Age ________ Residence: Mom Dad Both Other
Name ____________________________ Age ________ Residence: Mom Dad Both Other
Name ____________________________ Age ________ Residence: Mom Dad Both Other

How did you hear about our clinic? ____

Health History

Please check any of the following conditions that your child has had in the past.

Age at last occurrence/comments:

______ Asthma ____
______ Bronchitis ____
______ Chronic digestive issues ____
______ Croup ____
______ Chronic headaches ____
______ Multiple upper respiratory infections ____
______ Multiple ear infections ____
______ Ear tubes ____
______ Head injury ____
______ Seizures ____
______ Surgery ____
______ ADD/ADHD diagnosed ____
______ Hospitalization ____
______ Digestive problems: constipation/diarrhea ___________________________________
______ Other: ____________________ ____

Other Health Considerations:

Birth complications: ____
Describe your child's temperament as a baby: _____ Average ______ Challenging
Are there any pets in child's household? ____ Type: ___________________________________
Does anyone in the household smoke? ____
Has your child been administered a TOVA test? _____________________________________

At what age did your child:

Give up naps: ______________
Sleep through the night: ___________
Drink with a cup: __________
Eat with a spoon: __________

Does your child have any of the following: (please explain)

Allergies? ____
Drug allergies? ____
Food allergies? ____
Has your child been allergy tested? ________ By whom? ____________________________
Hearing issues? ____
Special education needs/assessment? _______________________________________
Prescription medications/nutritional supplements? ______________________________
____

Has your child experienced any of the following:

_______ Anxiety
_______ Death of close person
_______ Depression
_______ Divorce
_______ Sleep issues
_______ Drop in school grades
_______ Food issues
_______ School behavior issues
_______ Social issues
_______ Loss of pet
_______ Sexual abuse
_______ Seriously ill parent
_______ Move
_______ New sibling
_______ Nightmares
_______ Obsessive behavior
_______ Separation anxiety
_______ Irrational fears
_______ Change of school
_______ Learning issues
_______ Physical abuse
_______ Emotional abuse
_______ Other family trauma: ____

Information on Immediate and Extended family:

Has anyone in the immediate/extended family been diagnosed or treated for any of the following:

	Relationship to child:
_______ Schizophrenia	______________________________
_______ Major Depression	______________________________
_______ Manic Depressive disorder	______________________________
_______ Bipolar	______________________________
_______ Alcoholism/drug abuse	______________________________
_______ Suicide	______________________________
_______ ADD/ADHD	______________________________
_______ Other ____________________	______________________________

Has anyone in the child's immediate family been in therapy before? __________________
Whom? ____

Please tell us why you have brought your child to us today? __________________________
____
____