Wilfred G. Van Gorp, Ph.D.
Center for Cognitive Assessment
240 Central Park South, Suite 2B
New York, NY 10019
212-247-1350

PATIENT INTAKE FORM

Childs Name:_____ Date of Birth:_____

Grade in School: _____ Name of School: _____

Ethnicity: _____

Child's Primary Care Physician: _____

_____

Social Security Number: _____

Mother's Name: _____

Mother's Date of Birth: _____Home Telephone#:_____

Home Address: _____

_____

Mother's Highest Level of Education: _____

Mother's Place of Employment: _____

Position at Work: _____

Work phone#:_____is it ok to call? _____ hours: _____

Father's Name: _____

Father's Date of Birth: _____Home Telephone#:_____

Father's Home Address: _____

_____

Father's Highest Level of Education: _____

Father's Place of Employment: _____

Position at Work: _____

Work Phone: _____ is it ok to call? _____ Hours: _____

REFERRAL INFORMATION:

Child Referred for Evaluation by: _____

Referral Sources relationship to your child: _____

What are your concerns about your child? Why are you seeking this evaluation?

_____

_____

_____

What do you think is causing your child's problem(s)? _____

_____

To date, what steps have been taken to deal with your concerns? _____

_____

_____

What are you child's strengths? _____

_____

_____

_____

Has your child had any past EVALUATIONS or received any past TREATMENTS? If yes, please list below. Please include copies of past evaluations when you return this intake form.

Date	Type of Treatment/Evaluation	Where?
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREGNANCY AND BIRTH INFORMATION:

My child is: biological_____ adopted____.

Mother's age at time of delivery: _____ Father's age at time of delivery: _____

What pregnancy was this (first, second, etc.)? _____ Weight gain during pregnancy_____

Length of pregnancy: _____ Baby's birth weight: _____

Name and location of hospital where child was born: _____

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Please check yes or no about possible conditions related to pregnancy and delivery of the child:

	No	Yes
Mother had prior miscarriage(s)	_____	_____ if yes, number _____
Mother had prior premature baby (ies)	_____	_____ if yes, number _____
Mother experienced frequent vomiting	_____	_____
Mother experienced bleeding in 1st 3 months	_____	_____
Mother experienced bleeding in 2nd 3 months	_____	_____
Mother experienced bleeding in 3rd 3 months	_____	_____
Mother experienced increased blood pressure	_____	_____
Mother had infection during pregnancy	_____	_____
Medication was prescribed during pregnancy	_____	_____

During pregnancy, mother:	No	Yes
Smoked:	_____	_____ if yes, # packs/day_____
Used alcohol	_____	_____ if yes, # drinks/week _____
Used drugs	_____	_____ if yes, type & amount_____
Was labor induced?	_____	_____ if yes, reason: _____
Was delivery difficult?	_____	_____ if yes, describe: _____
Was child delivered by Caesarean section?	_____	_____ if yes, reason: _____
Was mother put to sleep during delivery?	_____	_____

How many hours did labor last? _____

INFANCY:

Please check yes or no about possible problems in infancy your child may have experienced:

	No	Yes
Was the product of a twin/multiple birth?	_____	_____
Had trouble breathing at birth?	_____	_____
Born with umbilical cord wrapped around neck?	_____	_____

Please check yes or no about possible problems in infancy your child may have experienced:

	No	Yes
Required oxygen at birth:	_____	_____
Required hospitalization in Neonatal	_____	_____
Intensive Care Unit (NICU) # Days in hospital: _____	_____	_____ if yes, describe care and
Childs experience seizures:	_____	_____ if yes, describe_____
Child experience jaundice:	_____	_____
Child experience phototherapy (light treatment)	_____	_____
Child had an infection	_____	_____ if yes, describe: _____
Was born with birth defects	_____	_____ if yes, describe: _____
Had trouble sucking & feeding	_____	_____
Had colic	_____	_____ if yes, how long did it Last? _____

DEVELOPMENT: At what age was your child able to:

Sit without help: _____ speak first word (mama, dada): _____

Walk along: _____ put 2 words together: _____

Ride a 2-wheel bike: _____ speak in 2-3 word sentences: _____

Use a spoon: _____ tie she laces: _____

Start to dress self: _____ achieve daytime dryness: _____

Catch a ball: _____ separate from parent easily: _____

CHILD'S MEDICAL HISTORY:

Has your child ever been hospitalized or seen in an emergency room? _____no _____yes. If yes, please describe: _____

_____

List current medications your child is taking: _____

Does your child have allergies? _____no _____ yes (list): _____

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Are your child's immunizations up to date? ____ No _____ yes

Has your child ever had:

	No	Yes	Age and additional other information
Ear infections	_____	_____	_____
Hearing problems	_____	_____	_____
Tubes in ears	_____	_____	_____
Vision problems	_____	_____	_____
High lead level	_____	_____	_____
Anemia	_____	_____	_____
Asthma	_____	_____	_____
Slow weight gain	_____	_____	_____
Excessive weight gain	_____	_____	_____
Urinary problems	_____	_____	_____
Bowel problems	_____	_____	_____
Heart problems	_____	_____	_____
High fever ($^{<103}$ degrees)	_____	_____	_____
Seizures	_____	_____	_____

	No	Yes	
Loss of consciousness	_____	_____	_____
Head injury	_____	_____	_____
Headaches	_____	_____	_____
Meningitis / encephalitis	_____	_____	_____
Scarlet fever	_____	_____	_____
Strep throat	_____	_____	_____
Tick bit / Lyme Disease	_____	_____	_____
Broken bones	_____	_____	_____

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Please answer the following about your child's sleep patterns and habits.

Time put to bed on: School nights _____ Non-school nights _____

Time wakes up on: School nights _____ Non-school nights _____

If your child experiences any of the following sleep problems, please check:

has difficulty falling asleep: ____ wakes up during night: ____ estimate #times/night___

snores: ____ gasps for breath ____

nightmares: ____ restless sleeper (tosses and turns) ____

night terrors: ____ is an early riser: ____

Is hard to wake up in morning: ____

Has your child ever had any of the following procedures/evaluations performed?

	No	Yes	Age	Where Done	Results
Hearing:	___	___	___	_____	
Vision	___	___	___	_____	
EEG	___	___	___	_____	
CT Scan	___	___	___	_____	
Brain MRI	___	___	___	_____	

Other (describe): _____

FAMILY/HOME INFORMATION:

Please list all relatives and others with whom the child resides. Indicate their names, age, sex, relationship to child, and level of education.

Name	age	sex	relationship to child	education level

Please list immediate family members not living in the home (e.g., biological parent):

Name age sex relationship to child education level

_____

_____

If parents are divorced or separated, please describe who holds custody of child and visitation arrangements. If child does not reside in the home of a parent, explain why: _____

_____

What language (s) is spoken in the Home? _____

A child(s) problems can be related to or influenced by other problems. Has your family experienced any other the following circumstances in the past 2 years?

Separation ___ Divorce ___ Change of school ___

Change of residence ___ Addition to the family ___ Legal Problems ___

Illness of family member ___ financial stress ___ Parental loss/change of job ___

Other stress(es) _____

If you checked any other the above, please elaborate: _____

_____

_____

FAMILY MEDICAL HISTORY: *Listed below are a number of different medical, psychological and learning problems. Please place a check by those problems a family member has experienced, and also indicate the family member's relationship to the child (e.g. mother, father, sibling, aunt, uncle, cousin, grandmother, etc.) Please also indicate M for maternal family relatives or P for parental family relatives.*

Problem	Family Member
___ Hyperactivity	_____
___ Attention Problems/ADHD	_____
___ Reading Difficulties	_____
___ Dyslexia	_____
___ Math Difficulties	_____

___ Written Expression Problems _____

___ Handwriting Problems _____

___ Academic Underachievement _____

___ Speech Problems _____

___ Developmental Delays _____

___ Mental Retardation _____

___ Motor Problems _____

___ Childhood Behavioral Problems _____

___ Tics (repetitive twitches, utterances)_____

___ Obsessive-compulsive Behavior _____

___ Anxiety Problems _____

___ Depression _____

___ Alcohol Abuse _____

___Drug Abuse _____

___Other Psychiatric Problems

(Please describe) _____

___Convulsions/Seizures _____

___Migraine Headaches _____

___Brain Tumor _____

___Muscular Weakness _____

___Diabetes _____

___Thyroid Disease _____

___Heart Disease _____

___Hearing Impairment _____

___Visual Impairment _____

___Rheumatic Fever _____

___Other (please list) _____

CHILD'S RELATIONSHIPS TO OTHERS AND BEHAVIOR:

Describe how your child gets along with his or her:

Mother: _____

Father: _____

Siblings: _____

Other family members: _____

Describe how your child gets along outside of school with:

Boys his/her own age: _____

Girls his/her own age: _____

Younger children: _____

Adults: _____

Please describe your child's temperament and personality: _____

_____

_____

Who in the family usually manages/disciplines your child? _____

What have you found to be useful methods for managing/disciplining your child (e.g., using rewards, taking away privileges, isolation, spanking, etc.)? _____

_____

Please check any of the following behaviors your child displays:

Temper tantrums ___

Aggressive behaviors ___

Destructive behaviors ___

Cruelty to animal's ___

Fire setting ___

Lying ___

Stealing ___

Immaturity ___

Social awkwardness ___

shyness ___

anxiety ___

unusual fears ___

repetitive habits ___

unusual concerns ___

Oppositionality ___ withdrawn ___

Defiance ___ excessive sadness ___

Mood swings ___ stubborn ___

Drug/alcohol use ___ separation fears/anxiety ___

Truancy ___ eating problems ___

In trouble with neighbors ___ overly compliant ___

Check any of these behaviors that are of concern to you about your child:

Short attention span ___ reading problems ___

Reduced concentration ___ math problems ___

Easily distractible ___ written expression problems ___

Frequently off-task ___ poor handwriting ___

Impulsive ___ poor coordination ___

Restless ___ difficulty verbally expressing self ___

Hyperactive ___ difficulty adapting to change (e.g., rigid) ___

Disorganized ___ is forgetful ___

Difficulty listening when spoken to ___

SCHOOL EXPERIENCES:

School attended	Location	Grade Placements	Academic Performance

Has your child ever received or been involved in any of the following services:

	No	Yes	If Yes, Grade(s) or Age(s) at time of involvement
Early intervention	___	___	_____
Speech/Language Therapy	___	___	_____
Occupational Therapy	___	___	_____
Physical Therapy	___	___	_____

Academic Resource help ___ ___ _____

Outside of school tutoring ___ ___ _____

Learning Disability program ___ ___ _____

Academic Enrichment program ___ ___ _____

Counseling ___ ___ _____

Are you satisfied with your child's current school program? ___yes ___no.

If no, please describe your concerns. _____

_____

What do you think of this year's teacher? _____

Please describe how your child manages his or her homework. How many hours a night does he spend completing assignments? _____

_____

_____

How far would you like your child to go in school? _____

If there is other information you would like to share, please feel free to add comments here.

This form was completed by: _____

My relationship to the child: _____

Date form complete: _____

Please return this form to Dr. Van Gorp at address listed on page 1 of this form