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Intake Extension: Parent Management Training

Parent Management Training

General Information

Child's name:

Child's date of birth:

Guardian 1's name:

Guardian 1's date of birth:

Guardian 1's telephone number:

Guardian 1's home address:

Guardian 1's highest level of education:

Guardian 1's place of employment:

Guardian 1's position at work:

Guardian 1's work phone number:

Is it okay to call?:

Guardian 1 prefers to be contacted during these hours:

Guardian 2's name:

Guardian 2's date of birth:

Guardian 2's telephone number:

Guardian 2's home address:

Guardian 2's highest level of education:

Guardian 2's place of employment:

Guardian 2's position at work:

Guardian 2's work phone number:

Is it okay to call?:

Guardian 2 prefers to be contacted during these hours:

Referral Information

Parent training was referred by:

Referral source's relationship to child:

What are the main concerns?:

What do you think is causing the child's problem(s)?:

To date, what steps have been taken to deal with the concerns?:

What are the child's strengths?:

Pregnancy and Birth Information

My child is:

Mother's age at time of delivery:

Father's age at time of delivery:

What pregnancy was this?:

Weight gained during pregnancy:

Length of pregnancy:

Name and location of hospital where child was born:

Please check possible conditions related to pregnancy and delivery of the child (check all that apply)

- [ ] Mother had prior miscarriages
- [ ] Mother had prior premature baby(ies)
- [ ] Mother experienced frequent vomiting
- [ ] Mother experienced bleeding in the first trimester (months 1-3)
- [ ] Mother experienced bleeding in second trimester (months 4-6)
- [ ] Mother experienced bleeding in third trimester (months 7-9)
- [ ] Mother experienced increased blood pressure
- [ ] Mother had infection during pregnancy
- [ ] Medication was prescribed during pregnancy
- [ ] Other

During pregnancy, mother:

- [ ] Smoked
- [ ] Used alcohol
- [ ] Used drugs
- [ ] Other

If yes to any of the above, please provide additional information (type, frequency, quantity):

Was labor induced?:

Was delivery difficult?:

Was child delivered by Caesarean section?:

How many hours did labor last?:

Infancy

Possible problems in infancy the child may have experienced

- [ ] Was the product of a twin/multiple birth
- [ ] Had trouble breathing at birth
- [ ] Born with umbilical cord wrapped around neck
- [ ] Required oxygen at birth
- [ ] Child experienced jaundice
- [ ] Child experienced phototherapy
- [ ] Had trouble sucking & feeding
- [ ] Required hospitalization in Neonatal Intensive Care Unit (NICU)?

    If checked, describe care and # of days in NICU:

- [ ] Child experienced seizures?

    If checked, describe type, frequency and treatment:

- [ ] Child had an infection?

    If checked, describe type, frequency and treatment:

☐ Child was born with birth defects?

If checked, describe type and treatment (if any):

☐ Child had colic?

If checked, how long did it last?:

☐ Other

Describe other problems in infancy the child experienced:

Development

At what age was the child able to sit without help?:

Walk alone?:

Ride a 2-wheel bike?:

Use a spoon?:

Start to dress self?:

Catch a ball?:

Speak first word (e.g. mama, dada)?:

Put 2 words together?:

Speak in 2-3 word sentences?:

Tie shoelaces?:

Achieved daytime dryness?:

Separate from parent easily?:

Child's Medical History

Has the child ever been hospitalized or seen in an emergency room? If yes, please describe:

Does the child have allergies? If yes, list allergies and treatment (if any):

Has the child ever had (check all that apply):

- [ ] 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)
- [ ] Seizures
- [ ] Loss of consciousness
- [ ] Head injury
- [ ] Headaches
- [ ] Meningitis/Encephalitis
- [ ] Scarlet fever
- [ ] Strep throat
- [ ] Tick bite/ Lyme disease
- [ ] Broken bones
- [ ] Other

If yes to any of the above, please provide age and additional relevant information:

Sleep

Time put to bed on: School nights:

Time put to bed on: Non-school nights:

Time wakes up on: School mornings:

Time wakes up on: Non-school mornings:

The child experiences the following sleep problems (check all that apply)

- [ ] Has difficulty falling asleep
- [ ] Wakes up during the night (1-3 times)
- [ ] Wakes up during the night (4+ times)
- [ ] Snores
- [ ] Gasps for breath
- [ ] Nightmares
- [ ] Restless sleeper (tosses and turns)
- [ ] Night terrors
- [ ] Is an early riser
- [ ] Is hard to wake up in the morning
- [ ] Other

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

- [ ] Hearing
- [ ] Vision
- [ ] EEG
- [ ] CT Scan
- [ ] Brain MRI
- [ ] Other

If you checked any of the boxes above, please provide the child's age, location of procedure/evaluation, and results below:

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:

Please list immediate family members not living in the home (e.g. biological parent). Indicate their names, age, sex, relationship to child, and level of education:

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 the parent, explain why:

Language(s) spoken in the home:

A child(s) problems can be related to or influenced by other problems. Has the child's family experienced any other of 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)
- [ ] Other

If you checked any of the above, please elaborate:

Family Medical History

Listed below are a number of different medical, psychological and learning problems. Place a check by those problems a family member has experienced

- [ ] Hyperactivity
- [ ] Attention Problems/ADHD
- [ ] Reading Difficulties
- [ ] Dyslexia
- [ ] Math Difficulties
- [ ] Written Expression Problems
- [ ] Handwriting Problems
- [ ] Academic Underachievement
- [ ] Speech Problems
- [ ] Developmental Delays
- [ ] Intellectual Disability
- [ ] Motor Problems
- [ ] Childhood Behavioral Problems
- [ ] Tics (repetitive twitches, utterances)
- [ ] Obsessive-compulsive Behavior
- [ ] Anxiety Problems
- [ ] Depression
- [ ] Alcohol Abuse
- [ ] Drug Abuse
- [ ] Other Psychiatric Problems
- [ ] Convulsions/Seizures
- [ ] Migraine Headaches
- [ ] Brain Tumor
- [ ] Muscular Weakness
- [ ] Diabetes
- [ ] Thyroid Disease
- [ ] Heart Disease
- [ ] Hearing Impairment
- [ ] Visual Impairment
- [ ] Rheumatic Fever
- [ ] Other

If you checked any of the above, please indicate the family member's relationship to the child (e.g. mother, father, sibling, aunt, uncle, cousin, grandmother, etc). Also, please indicate M for maternal family relatives or P for parental family:

Child's Relationships to Others and Behaviors

Describe how the child gets along with his or her: Mother:

Describe how the child gets along with his or her: Father:

Describe how the child gets along with his or her: Sibling(s):

Describe how the child gets along with his or her: Other family members:

Describe how the child gets along outside of school with: Boys his/her own age:

Describe how the child gets along outside of school with: Girls his/her own age:

Describe how the child gets along outside of school with: Older children:

Describe how the child gets along outside of school with: Younger children:

Describe how the child gets along outside of school with: Adults:

Please describe the child's temperament and personality:

Who in the family usually manages/disciplines the child?:

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

Please check any of the following behaviors the child displays

- [ ] Temper tantrums
- [ ] Aggressive behaviors
- [ ] Destructive behaviors
- [ ] Cruelty to animals
- [ ] Fire setting
- [ ] Lying
- [ ] Stealing
- [ ] Oppositionality
- [ ] Immaturity
- [ ] Social awkwardness
- [ ] Shyness
- [ ] Anxiety
- [ ] Unusual fears
- [ ] Repetitive habits
- [ ] Unusual concerns
- [ ] Withdrawn
- [ ] Defiance
- [ ] Mood swings
- [ ] Drug/alcohol use
- [ ] Truancy
- [ ] In trouble with neighbors
- [ ] Excessive sadness
- [ ] Stubborn
- [ ] Separation fears/anxiety
- [ ] Eating problems
- [ ] Overly compliant
- [ ] Other

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

- [ ] Short attention span
- [ ] Reduced concentration
- [ ] Easily distractible
- [ ] Frequently off-task
- [ ] Impulsive
- [ ] Restless
- [ ] Hyperactive
- [ ] Disorganized
- [ ] Difficulty listening when spoken to
- [ ] Reading problems
- [ ] Math problems
- [ ] Written expression problems
- [ ] Poor handwriting
- [ ] Poor coordination
- [ ] Difficulty verbally expressing self
- [ ] Difficulty adapting to change (e.g., rigid)
- [ ] Is forgetful
- [ ] Other

School Experiences

School information: School name, location, grade placement, academic performance:

Has the child ever received or participated in any of the following services?

- [ ] Early Intervention
- [ ] Speech/Language Therapy
- [ ] Occupational Therapy
- [ ] Physical Therapy
- [ ] Academic Resource Help
- [ ] Outside of School Tutoring
- [ ] Learning Disability Program
- [ ] Academic Enrichment Program
- [ ] Counseling
- [ ] Other

If you checked any of the above, please provide grade(s) or age(s) at the time of involvement:

Do you have any concerns with this year's teacher?:

Please describe how the child manages his or her homework. How many hours a night does he/she spend completing assignments?:

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

Completion

This form was completed by:

My relationship to the child:

Date form completed: