Manhattan Psychology Group, PC
107 West 82nd St Suite P101
New York NY 10024
646-389-4112

Testing Intake Questionnaire: Child/Adolescent

General Information

Child's name:

Child's date of birth:

Child height and approximate weight:

Child left or right handed:

Child identifying features (hair,eye color):

Race/Ethnicity:

School and Grade:

Classroom Teacher (name and contact information):

Does your child have an IEP? If so, why?:

Guardian 1's name and relationship:

Guardian 1's date of birth:

Guardian 1's telephone number:

- Home:
- Cell:
- Work:

Guardian 1's email address:

Guardian 1's home address:

Guardian 1's highest level of education:

Guardian 1's place of employment:

Guardian 1's position at work:

Is it okay to call?:

Guardian 1 prefers to be contacted during these hours:

Guardian 2's name and relationship:

Guardian 2's date of birth:

Guardian 2's telephone number:

Home:

Cell:

Work:

Guardian 2's email address:

Guardian 2's home address:

Guardian 2's highest level of education:

Guardian 2's place of employment:

Guardian 2's position at work:

Is it okay to call?:

Guardian 2 prefers to be contacted during these hours:

Referral Information

Who referred you for the evaluation? Please list the name and organization:

What are your main concerns? Why is your child being evaluated?:

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

What questions would you like the evaluation to try to answer? (please be as detailed as possible):

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

Has your child been evaluated or tested previously? Please list dates and type of evaluation:
Please email PDF's of previous evaluation reports.

Has your child received talk therapy or counseling before? Please list dates and type of service (outpatient, inpatient, school counseling) and locations:

What are the child's strengths?:

Pregnancy and Birth Information

My child is (birth order):

Mother's age at time of delivery:

Father's age at time of delivery:

What pregnancy was this?:

Was the product of a twin/multiple birth?:

Any complications with the pregnancy?:

Mother had prior miscarriages?:

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

- [ ] Child exposed to smoke, alcohol, drugs, other toxins
- [ ] Mother experienced frequent vomiting
- [ ] Mother experienced bleeding in the first trimester (months 1-3)
- [ ] Mother experienced bleeding in the second trimester (months 4-6)
- [ ] Mother experienced bleeding in the third trimester (months 7-9)
- [ ] Mother experienced increased blood pressure
- [ ] Mother had infection during pregnancy
- [ ] Medication was prescribed during pregnancy

Any complications with the birth?:

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

- [ ] Was labor induced?
- [ ] 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 and feeding

Was delivery difficult:

Was child delivered by Caesarean:

How many hours did labor last?:

Did your child spend any time in the NICU? If so, why?:

Was your child born full-term (38 weeks)? If not, please list number of weeks:

Name and location of hospital where child was born:

- [ ] 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?:

Jump and run:

Ride a 2-wheel bike?:

Feed self with a spoon?:

Start to dress self?:

Catch a ball?:

Speak first word (e.g. cat, ball, cup)?:

Put 2 words together (e.g. Want please, Big dog)?:

Speak in 2-3 word sentences (e.g. Give to me, I want juice)?:

Tie own shoelaces?:

Achieved daytime dryness?:

Separate from parent easily?:

Fully toilet trained?:

Child’s Medical History

Child's primary care physician (name, address, phone, email):

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

List current medications the child is taking (with dose):

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

Are the child's immunizations up to date?:

Does the child have a history of any head injuries, including during sporting events?:

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

- [ ] Ear infections
- [ ] Hearing problems
- [ ] Tubes in ears
- [ ] Vision problems
  - Date of last vision exam:
  - Does the child wear glasses?
- [ ] High lead level
- [ ] Anemia
- [ ] Asthma
- [ ] Slow weight gain
- [ ] Excessive weight gain
- [ ] Anorexia
- [ ] Bulimia
- [ ] Urinary problems
- [ ] Bowel problems
- [ ] Heart problems
- [ ] High fever (>103)
- [ ] Seizures
- [ ] Loss of consciousness
- [ ] Headaches
- [ ] Meningitis/Encephalitis
- [ ] Strep throat
- [ ] Tick bite/ Lyme disease
- [ ] Broken bones
- [ ] Other

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

Has your child ever had an EEG, CT Scan, or an MRI of the head?:

Mental Health History

Has your child ever seen a counselor, therapist, psychologist or psychiatrist? If so, please provide the dates, name of provider, and contact information:

Why was your child referred to a mental health professional [counselor, therapist, psychologist or psychiatrist]?:

Has your child ever been in a psychiatric hospital? If so, please provide the dates, name of provider and contact information:

Has your child ever taken psych meds/psychotropic medication? If so, please provide the name, dates, and dose:

Have you ever had concerns about your child and self-harm/suicide?

Sleep

What time does your child go to bed on school nights?:

What time does your child go to bed on non-school nights?:

What time does your child wake up on school mornings?:

What time does your child go to bed on non-school mornings?:

Does your child have any of the following sleep issues? (check all that apply)

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

Specify other:

Family/Home Information

Who lives in the home with you and your child? Please list names and ages.:

If any immediate family members (sibling, parent) live in another home, please list names and ages.:

If parents are divorced or separated, please describe who holds custody of child and visitation arrangements:

- [ ] Mother has legal custody (decision making power)
- [ ] Mother has physical custody (child lives with mother at least some time)
- [ ] Father has legal custody (decision making power)
- [ ] Father has physical custody (child lives with father at least some time)
- [ ] Parents have a custody order filed in a family court

Is child in foster care or residing in another home other than with immediate family (parents, siblings)?:

Child’s primary language:

Child’s secondary language:

Parent's primary language:

Parent's secondary language:

Has your child or your family experienced any other of the following events during the child's lifetime?

- [ ] 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
- [ ] Incarceration of a parent (at any time in the past)
- [ ] Domestic violence between parents/caregivers (at any time in the past)
- [ ] Substance (drugs or alcohol) abuse by a parent (at any time in the past)

Family Psychological History

Listed below are a number of different medical, psychological and learning problems. Place a check by those problems a family member (other than the child who is being referred for evaluation treatment) has experienced.

If you check any of the below, 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.

Is there a history of any of the following? If yes, list name, relation, and age.

- [ ] 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

Family Medical History

Is there a history of any of the following? If yes, list name, relation, and age

- [ ] Convulsions/Seizures
- [ ] Migraine Headaches
- [ ] Brain Tumor
- [ ] Muscular Weakness
- [ ] Diabetes
- [ ] Thyroid Disease
- [ ] Heart Disease
- [ ] Hearing Impairment
- [ ] Visual Impairment
- [ ] Other

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
- [ ] Oppositional attitude/behavior
- [ ] Immaturity
- [ ] Social awkwardness
- [ ] Poor hygiene
- [ ] Poor social skills
- [ ] Shyness
- [ ] Withdrawn
- [ ] Defiance
- [ ] Mood swings
- [ ] Drug/alcohol use
- [ ] Truancy from school
- [ ] Trouble with neighbors
- [ ] Excessive sadness
- [ ] Self harm (hitting or cutting themselves)
- [ ] Suicidal thinking or behavior (talking/writing/drawing about dying)
- [ ] Stubborn
- [ ] Separation fears/anxiety
- [ ] Eating problems

- [ ] Anxiety
- [ ] Unusual fears
- [ ] Repetitive habits
- [ ] Unusual concerns
- [ ] Overly compliant
- [ ] Other (please explain):

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

- [ ] Short attention span
- [ ] Problems concentrating
- [ ] Easily distracted
- [ ] Frequently off-task
- [ ] Impulsive
- [ ] Restless
- [ ] Hyperactive
- [ ] Disorganized
- [ ] Has difficulty listening when spoken to
- [ ] Reading problems
- [ ] Math problems
- [ ] Written expression problems
- [ ] Poor handwriting
- [ ] Poor spelling
- [ ] Poor physical coordination
- [ ] Difficulty verbally expressing self
- [ ] Difficulty adapting to change (e.g., rigid)
- [ ] Is forgetful
- [ ] Other (please explain):

School Experiences

School information

School name:

Location/address of school:

Current grade of child:

Name of teacher(s)/aide(s) best known to child:

Does your child currently have an IEP?:

Does your child currently have a 504 plan?:

How is your child doing in school?:

Do you have any concerns about the school year or your child’s education?:

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
- [ ] School-based counseling
- [ ] Outside of school counseling
- [ ] Other (please explain):

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

Do you have any concerns about 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?:

How far would you like the child to go in school?:

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

Intake form provided by:

This form was completed by:

My relationship to the child:

Date form completed:

Signature of person completing the form: