New Client Questionnaire--Child

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Please complete and return BEFORE your first scheduled appointment if at all possible. This questionnaire provides historical information to assist me in developing an individualized approach to working with your child. This information is confidential and will be released only with a signed release of information or in situations in which the law requires clinicians to make exceptions to confidentiality.

Person completing form ______________________________ Relationship ____________________ Date________

Child's full name ____ ☐M ☐F

Age_______ Birthdate_______________ Grade_____ Child lives with: _____________________

Parent ______________________________________ Occupation__________________________________

☐ Married ☐ Divorced ☐ Single ____

Address ____

(street/P.O. Box) (city) (state) (zip)

Email Address ____

Phone (Home/Work)_________________________ (Cell) ____________________________________

(**Please put a * by the preferred contact number**)

Parent ______________________________________ Occupation__________________________________

☐ Married ☐ Divorced ☐ Other ____

Address(if different) ____

(street/P.O. Box) (city) (state) (zip)

Email Address ____

Phone (Home/Work)_________________________ (Cell) ____________________________________

(Please put a * by the preferred contact number)

Step-parent/significant other____________________ Step-parent/significant other___________________

Language(s) spoken at home: _______________________________________First language_____________

Children in the family, first-born to last, gender, age:

1.____ 2.____

3.____4.____

Referred by: ____

Other family members seen here: ☐ Yes ☐ No ____

(name)

What concerns led to you making this appointment?

1.____

2. ____

3. ____

What are your priorities/goals for my work with your child?

1. ____

2. ____

3. ____

4. ____

Have you consulted with other agencies, clinics, or professionals about these concerns? ☐ Yes ☐ No
If so, please describe: ____

____

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Has anyone in your family had similar challenges? ☐ Yes ☐ No If so, please describe:

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Is there a family history of: (including extended family—please describe below)

☐ learning disability/dyslexia ☐ ADD/ADHD (attention problems, hyperactivity)
☐ speech or language disorders ☐ autism/spectrum disorders
☐ inherited medical condition ☐ developmental disabilities
☐ emotional/behavioral disorders ☐ psychiatric illness

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Medical Information/Developmental History:

Were there problems/concerns with ☐ pregnancy ☐ labor & delivery? ☐ during the newborn period?
If so, please describe: ____

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Were developmental milestones achieved within normal time frames? ☐ Yes ☐ No Describe below:

____

____

____

____

Has your child experienced:

☐ serious illnesses ☐ chronic ear infections/tubes ☐ injury or trauma to the head
☐ sleep difficulties ☐ allergies ☐ seizures

Does your child have a prior or current diagnosis of: ☐ ADHD/ADD ☐ anxiety or depression
If yes, describe the treatment: ____

____

____

____

Educational History:

Did you/your child have any developmental delays requiring early intervention? ☐ Yes ☐ No

What services were provided and when?

☐ Speech and/or Language Therapy ____

☐ Occupational Therapy ____

☐ Physical Therapy ____

☐ Social Skills Training ____

Current School ____________________ District (if applicable) ____________ Grade ________

Teacher (s)____

Contact number/email address: ____

Has your child repeated any grades? _______grade Reason: ______________________________

____

____

List all schools attended	Grade(s)	Special Education or Support Services provided

Please describe any evaluation(s) done by the school and your understanding of the results:

Private Services provided (tutoring, private OT/PT, speech or language therapy, counseling, etc.)

Please attach all pertinent evaluations, IEPs, reports/report cards that would help me understand your child's learning needs.

Strengths/Challenges:

List your child's strengths:

List your child's particular areas of interest: