CHILD INTAKE FORM

MELISSA HUY, PH.D, Inc.
Licensed Clinical Neuropsychologist
Lic. #: PSY 18078
4811 Eureka Avenue, Suite G-4, Yorba Linda, California 9288
(714) 936-0528 DrMelissaHuy@Gmail.Com

Today's date: _____

Demographic Information:

Patient's name:_____
Date of Birth:_____Age:_____
Ethnicity:_____Country of birth:_____
Languages spoken_____ at what age did child learn second language_____
current percent spoken in each language:____/____
Handedness: Right___ Left___ Ambidextrous___ Gender: Male___ Female___
Any family members left-handed: Yes___ No___

With whom is child currently residing?_____

Child's Address: _____

Mother's name:_____
Mother's Address (if different than child):_____
Mother's telephone: (c)_____(w)_____ (email)_____

Father's Address (if different than child):_____
Father's telephone: (c)_____(w)_____(email)_____

Parents Current Marital Status: _____ Legal Custody Arrangement:_____

Referral Source:_____
Has child ever had neuropsychological testing in the past? Yes___ No___ When last tested? ___
Primary care physician:_____Telephone:_____
Psychiatrist: _____Telephone:_____
Psychologist: _____Telephone:_____

Presenting Problem (be as specific as you can: describe problems, when did it start...):

_____
_____
_____
_____
_____
_____

Estimate the severity of above problem: ___Mild___Moderate___ Severe___ Very Severe

Academic History

Current School_____ Teacher(s)_____
Typical grades child earns:
Math____Reading____ Spelling____ Writing____ Science____ Comprehension____
Elective__

Special Education/IEP information:

_____
_____
_____
_____
_____

Gate Program? Yes ___No ___
Child's strengths and weakness in school_____
_____
_____
Any family history of learning difficulties or attention problems?_____
Have teachers had any concerns about your child behaviorally or academically?_____
_____

Educational achievement of immediate family members:_____

Medical History

Any difficulties during pregnancy/birth? No___ Yes _____
Developmental History:
O= On time E = Early D = Delayed
____Crawling ____Sitting____Standing ____Walking ____Talking ____Toilet Training

Early Intervention? (ages 0-3) If yes, please describe

- Speech/Language Therapy_____
- Occupational Therapy_____
- Physical Therapy_____
- Other _____

Between age 3 and current grade, did your child receive any therapies? If so, describe:

_____
_____

Please list any previous hospitalizations and or surgeries beginning with the most recent:

Reason	Date
_____	_____
_____	_____

Please list current and past medications (those for medical and psychological reasons)

Medication	For treatment of:	From (mo/yr)	To (mo/yr)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

History of a head trauma (i.e., MVA, fight, fall)? Yes___ No___
If yes, list date(s) and give a brief description:
Date cause length of LOC Symptoms

Brain Imaging and other Laboratory Results:

Any changes with eating/appetite? Yes___ No___ If yes, explain
Problems with sleep? Yes___ No___ If yes, any problems with (circle) initiating, maintaining, or early morning awakening. If yes, duration How many hours a night of sleep
Color blind? Yes___ No___
Vision problems? Yes___ No___ If yes, explain
Hearing problems? Yes___ No___ If yes, explain
Please list all that currently apply or have applied in the past:

___Allergies
___Arteriosclerosis
___Arthritis
___Blood Disorder
___Cancer or chemotherapy
___Hazardous substance exposure
___High blood pressure
___Diabetes
___Heart disease
___Multiple Sclerosis
___Kidney disease
___Liver disease
___Lung Disease
___Malnutrition
___Polio
___Radiation exposure or therapy
___Thyroid disorder
___Headaches
___Injury to arms, hands, or shoulders
___Past/present drug/alcohol use/abuse

Describe any serious Medical conditions
Any family Medical Issues?

Any current or past Psychiatric Diagnosis?
Please list any psychiatric hospitalizations:
Dates Diagnosis/Condition Treatment

Any current or past psychotherapy or psychiatric care? Yes___ No___ (i.e., depression, anxiety).
If yes, why were you treated, dates of service and was it helpful

Suicide attempts: No___ Yes,___please include dates and circumstances

Any close blood relatives have any history of mental illness (i.e., depression, bipolar disorder, schizophrenia, anxiety disorder, or ADD/ADHD, etc.)

Life stressors (circle): school, friends/ poor social support, economic, housing, health problems, transportation problems, access to health care services, other_____

Behavior and Mood

Please complete this form with your child if they are unable to complete on their own.
How would you describe your mood most days? (i.e., happy, sad, irritable, etc.).

_____
_____
_____
_____
_____
_____
_____
_____

Please check any of the following symptoms that you are currently experiencing or have experienced in the past, and indicate when these symptoms were present:

	From (mo/yr) to (mo/yr)
___Sad mood, crying or depression	_____
___ Recurrent thought of death or suicide	_____
___Self injurious behavior (cutting or other behavior)	_____
___Mood swings	_____
___Irritability/Anger	_____
___Euphoria (feeling on top of the world)	_____
___Anxiety, nervousness or overwhelmed	_____
___Racing thoughts	_____
___Feeling "panicked" or panic attacks	_____
___Impulsive or reckless behaviors	_____
___Recurrent thought that make you feel anxious	_____
___Repetitive behaviors (e.g., hand washing, checking things) or Mental acts (e.g., counting, repeating words silently)	_____
___Seeing things that other people in the room couldn't see	_____
___Hearing things that other people in the room couldn't hear	_____
___Smelling things that other people in the room couldn't smell	_____
___A feeling that you are being followed or watched	_____
___A feeling that someone is out to hurt or harm you in some way	_____
___Unhealthy eating style (restricting/binge eat)	_____

<u>Family/Social History:</u>

Child's siblings (name, age, statement about their relationship)

_____
_____
_____

If parents are divorced, what was the child's age at the time____and how did it affect the child?

_____
_____

Describe your child's recreational activities/hobbies:_____

_____

Describe your family's strengths:_____

_____

Describe your child's current level of support: Excellent___ Adequate___ Good___ Poor___

How would you describe child's current relationships with friends and family?_____

_____

_____

Discipline problems at home? Yes ___No ___ What works?_____

Is spirituality/faith an area of support for your child? ____Yes ____No
Religion: ___Catholic ___Christian___Jewish ___Mormon ___Islamic ____Buddhist ___Other
Would you like your child to receive Christian based counseling when appropriate:
____Yes ____No ____Maybe, please let me know before speaking with my child

Are you involved in any current or pending civil or criminal litigations, lawsuits, divorce or custody disputes: if yes, please explain:_____

_____

_____

Please use this space to include any other pertinent information you would like me to have regarding your child.

_____

_____

_____

_____

_____	_____	_____
Parent/Guardian Name (print)	Parent/Guardian Signature	Date

_____	_____	_____
Parent/Guardian Name (print)	Parent/Guardian Signature	Date