

**Developmental Neuropsychology Services, PLLC**  
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**Intake Questionnaire: Child Data Form**

Child's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Gender (circle one): Male Female

Ethnicity: \_\_\_\_\_

Person filling out this form (circle one): Mother Father Stepmother Stepfather

Other (please explain): \_\_\_\_\_

**Parents / Guardians/ Family** (Please circle Birth, Adoptive, or Foster)

**Birth / Adoptive / Foster Mother's Name:** \_\_\_\_\_ Education: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Home mailing address including zip code: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Birth / Adoptive / Foster Father's Name:** \_\_\_\_\_ Education: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Home mailing address including zip code: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Stepmother's Name:** \_\_\_\_\_ Education: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Home mailing address including zip code: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Stepfather's Name:** \_\_\_\_\_ Education: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Home mailing address including zip code: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Other Guardian Name(s):** \_\_\_\_\_ Education: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Home mailing address including zip code: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

List all people living in household:

<i>Name</i>	<i>Age</i>	<i>Relationship to Child including biological, foster, or adoptive</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If any brothers or sisters are living outside the home, list their names, ages, where they are living, and why they are no longer in your home: \_\_\_\_\_

Primary language spoken in the home: \_\_\_\_\_

Other languages spoken in the home: \_\_\_\_\_

### **Referral Information**

Briefly describe the child's current difficulties: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long has this been of concern to you? \_\_\_\_\_

What seems to help the situation? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What seems to make this situation worse? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has the child received evaluation or treatment for the current issue or similar issues? Yes \_\_\_\_ No \_\_\_\_

If yes, when and with whom? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is the child on any medication **at this time**? Yes \_\_\_\_ No \_\_\_\_

If yes, list medication (s), dosages, and name of professional monitoring your child's medication. Also indicate your child's response to the medications, both positive and negative effects.

\_\_\_\_\_

\_\_\_\_\_

Who referred you for evaluation and/or treatment?

\_\_\_\_\_

Describe the best things about your child: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have there been any major changes within the family life or the child's living situation that have affected your child's development (e.g., deaths, moves, divorces, loss of job, etc.)? \_\_\_\_ No \_\_\_\_ Yes (describe below)

EVENT DATE CHILD'S AGE

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If parents are separated or divorced, who has physical custody of the child? \_\_\_\_\_

Who has legal custody? \_\_\_\_\_

How often does the other parent see the child (check one) N/A \_\_\_\_\_

Weekly or more often \_\_\_\_ Once or twice a month \_\_\_\_ Few times a year \_\_\_\_ Never \_\_\_\_

\_\_\_\_\_

Please list any medications your child has received in the past for medical concerns (psychological/behavioral problems will be discussed later). Also describe what sort of response (e.g., effective, slightly effective, not effective). Also list specific side effects, if any. Use the margins or additional paper if necessary.

*Date Started*    *Date Stopped*    *Medication*    *Dose*    *Response*    *Reason for Medication*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Medical Care

Child's physician \_\_\_\_\_ Telephone \_\_\_\_\_

Physician's Mailing Address \_\_\_\_\_

How often does your son or daughter see a doctor? \_\_\_\_\_ Date of last visit \_\_\_\_\_

Has your son or daughter ever had psychological counseling or therapy? Yes \_\_\_\_ No \_\_\_\_

If yes, counselor's name \_\_\_\_\_

Counselor's Address \_\_\_\_\_

Telephone \_\_\_\_\_

Type of counseling and for what issues \_\_\_\_\_

When \_\_\_\_\_

Did you find it helpful? \_\_\_\_\_ No \_\_\_\_\_ Yes

Has your son or daughter ever attempted suicide? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when? \_\_\_\_\_ How? \_\_\_\_\_

Please describe the circumstances that led up to the suicide attempt: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did your son or daughter receive any therapy after this suicide attempt? Yes \_\_\_\_\_ No \_\_\_\_\_

Has your son or daughter ever talked about wanting to hurt him/herself? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when? \_\_\_\_\_

Please describe the circumstances that led up to the suicidal ideation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did your son or daughter receive any therapy after talking about harming him/herself?

Yes \_\_\_\_\_ No \_\_\_\_\_

Has your son or daughter ever had a neurological exam? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, neurologist's name \_\_\_\_\_ Date of Exam \_\_\_\_\_

Neurologist's Address \_\_\_\_\_

Has your son or daughter ever had a psychiatric evaluation? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, doctor's name \_\_\_\_\_ Date of Evaluation \_\_\_\_\_

Doctor's Address \_\_\_\_\_

Reason for exam \_\_\_\_\_

Has your son or daughter ever been hospitalized in a psychiatric facility? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when? \_\_\_\_\_ Where? \_\_\_\_\_

Reason? \_\_\_\_\_

Please list any and all diagnoses your child has been given (e.g., ADHD, Learning Disabled, PDD, Tourette's, Bipolar, Depression, Anxiety, Asperger's Disorder)

\_\_\_\_\_

\_\_\_\_\_

Please list any medications your child has received in the past for psychological/behavioral problems. Also describe what sort of response (e.g., effective, slightly effective, not effective). Also list specific side effects, if any.

<i>Date Started</i>	<i>Date Stopped</i>	<i>Medication</i>	<i>Dose</i>	<i>Response</i>	<i>Prescribing Physician</i>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Social and Behavior Checklist**

Place a check next to the following categories indicating whether you see this area as a strength or an area of concern for your son or daughter.

<i>Strength / Concern</i>			<i>Strength / Concern</i>		
_____	_____	Interactions with peers	_____	_____	Interactions with siblings
_____	_____	Anger management	_____	_____	Interactions with strangers
_____	_____	Activity level	_____	_____	Attention
_____	_____	Persistence	_____	_____	Planning activities, tasks
_____	_____	Energy level	_____	_____	Self-control
_____	_____	Problem solving	_____	_____	Discussing fears
_____	_____	Expressing feelings	_____	_____	Interaction with authority figures

Since age 5 has your child ever demonstrated the following. Check N/A \_\_\_\_\_ if your child is not yet 5.

- \_\_\_\_\_ No \_\_\_\_\_ Yes      Anxiety or oversensitivity to new experiences
- \_\_\_\_\_ No \_\_\_\_\_ Yes      Verbal aggression such as profanity, making threats and/or disruptive vocalizations
- \_\_\_\_\_ No \_\_\_\_\_ Yes      Lack of attentiveness
- \_\_\_\_\_ No \_\_\_\_\_ Yes      Wandering, running away, roaming
- \_\_\_\_\_ No \_\_\_\_\_ Yes      Hyperactivity – inability to sit still or restlessness
- \_\_\_\_\_ No \_\_\_\_\_ Yes      Engages in compulsive rituals
- \_\_\_\_\_ No \_\_\_\_\_ Yes      If yes, please describe: \_\_\_\_\_
- \_\_\_\_\_ No \_\_\_\_\_ Yes      Inability to make friends
- \_\_\_\_\_ No \_\_\_\_\_ Yes      Physical aggression such as hitting, biting, punching, kicking, spitting
- \_\_\_\_\_ No \_\_\_\_\_ Yes      Constant fighting with siblings or peers

- |                             |                              |  |
|-----------------------------|------------------------------|--|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Property destruction   |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Extreme withdrawal – social isolation – shyness                                    |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Sudden weight gain or loss   |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Eating objects which are not meant to be eaten                                     |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Self-injurious behavior such as head banging, head slapping, hair pulling, cutting |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Nervous habits such as tics: If yes, please describe: _____                        |
| <hr/>                       |                              |  |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Thumbsucking   |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Grinding teeth, clicking teeth   |

Please explain any “yes” responses:

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Do you have concerns related to your child’s ability to control their temper (i.e., tantrums)? Yes\_\_\_ No\_\_\_

If yes, please describe your concerns:\_\_\_\_\_

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**Educational History**

At what age did your child start going to school? \_\_\_\_\_

How did your child react to starting school? \_\_\_\_\_

School History: (please write in the names of the schools with the approximate dates of attendance)

Pre-school: \_\_\_\_\_ Dates: \_\_\_\_\_

Kindergarten: \_\_\_\_\_ Dates: \_\_\_\_\_

Elementary: \_\_\_\_\_ Dates: \_\_\_\_\_

\_\_\_\_\_ Dates: \_\_\_\_\_

Middle School: \_\_\_\_\_ Dates: \_\_\_\_\_

\_\_\_\_\_ Dates: \_\_\_\_\_

High School: \_\_\_\_\_ Dates: \_\_\_\_\_

\_\_\_\_\_ Dates: \_\_\_\_\_

Current School: \_\_\_\_\_ Current grade: \_\_\_\_\_

Current teacher or other school contact: \_\_\_\_\_ Phone: \_\_\_\_\_

*Please check what you feel best describes your son / daughter in the following areas:*

<b>ATTENDANCE</b>	<b>ABILITY</b>	<b>RELATIONS WITH CLASSMATES</b>	<b>BEHAVIOR</b>
Rarely absent	Above average	Above average	Above average
Sometimes absent	Average	Average	Average
Often absent	Below average	Below average	Below average

*Place a check next to the following categories indicating whether you see the area as a strength or an area of concern for your son or daughter.*

<i>Strength / Concern</i>	<i>Strength / Concern</i>	<i>Strength / Concern</i>
_____	Reading	Other subjects (list below)
_____	Arithmetic	_____
_____	Spelling	_____
_____	Writing	_____
_____	Relationship with teachers	_____

Has your son or daughter received any special education services (e.g., Title I, 504 accommodations, speech/language, adaptive physical education, occupational therapy, classroom aide, etc.)?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what type of service(s)? \_\_\_\_\_

When did the school last evaluate your child? \_\_\_\_\_

Has your son or daughter been retained a grade? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, which grade(s) and why? \_\_\_\_\_