Behavioral Intake

Childs Name_____
Date of Birth_____

What are your main concerns about your child's behavior?

Medical History

- Problems During Pregnancy? _____
  _____
  _____
- Medication taken during pregnancy?_____
- Was your child premature? ___ No ___ Yes (How many weeks?_____)
- How was child delivered? ____Vaginal ____ C-Section
- Birth Weight _____
- Were any of the following used during pregnancy? _____ Marijuana _____ Other Drugs
  _____ Alcohol _____ Cigarettes
- Any history of hospitalizations/Surgeries since Birth? _____ No _____ Yes (Please Explain)

_____
_____

- Any history of Head Injury or Loss of Consciousness? ____ No _____ Yes (Please Explain)

_____
_____

- Currently taking any medication or supplement? _____ No _____ Yes (Please List) _____

_____
_____

- Allergies to medications? _____ No _____ Yes (Please List) _____

_____
_____

- Any medical concerns or problems? _____ No _____ Yes (Please choose or List)

_____ Headaches ____ Allergies/Asthma ____ Bed-wetting
_____ Abdominal Pain ____ Sleep Problems ____ Constipation
_____Unusual Movement/Seizures _____ Hearing/Vision concerns
_____ _____ _____

- Treatments Previously Tried

_____ Counseling _____ Vitamins _____ Over the counter medication
_____ Diet _____ Behavioral Therapy

Family History

	Father	Mother	Brother	Sister	Mothers Side	Fathers Side
Aggressive Behavior						
Defiant/Oppositional Behavior						
Attention Problem						
Problms with impulse control						
Learning Disabilities						
Failed to graduate from High School						
Mental retardation						
Depression						
Schizophrenia						
Bipolar						
Anxiety Disorder						
Tics or Tourettes						
Alcohol Abuse						
Substance Abuse						
ADD/ADHD						
Arrest						
Physical Abuse						
Sexual Abuse						
Thyroid Problems						

Social History

- List who lives at home with the child?

Name *Age* *Relationship*

_____

_____

_____

_____

_____

_____

- Mother or Guardian Employment:_____
- Father or Guardian Employment:_____
- Is mother or father or guardian home on the evening or weekends? Mother____ No ____ Yes
  Father ____ No ____ Yes
  Guardian ____ No ____ Yes

  If no one is home on evenings or weekend who watches the child? _____

  _____
- How does the child get along with his/her brothers or sisters?

Does not have any siblings:_____ Gets along well:_____

Has problems (Please Describe) _____

_____

- Any family stress? ____ No _____ Yes (Please Explain) _____

_____

- Lives with parents or guardians that are divorced or separated? ____ No ____ Yes
- Parent or guardian has died? ____ No ____ Yes
- Lives with parent or guardian who has served time in jail or prison? ____ No ____ Yes
- Lives with someone who has mental illness, suicidal or severe depression? ____ No ____ Yes
- Lives with someone who has problems with drugs or alcohol?____ No ____ Yes
- Has witnessed a parent or guardian or other adult in the household behaving violently towards another person? ____ No ____ Yes
- Has been a victim of violence or witness any violence in his or her neighborhood? ____ No ____ Yes
- Has experienced economic hardship "somewhat often" or "very often"? ____ No ____ Yes

- Sleep Pattern

  In bed at what time:_____ Asleep by:_____

  Wake at what time: _____ Snores frequently: ____ No ____ Yes

  TV/Electronics in bedroom at night: ____ No ____ Yes

  Feels rested in morning ____ No ____ Yes
- Diet

Any special diet: ____ No _____ Yes (Please Explain) _____

Do any foods effect behavior? ____ No _____ Yes (Please Explain) _____

- How much caffeine does child drink in a day? _____

School History

Previous School Problem by Grade (Please check those that apply)

	K	1st	2nd	3rd	4th	5th	6th	7th	8th	9th-12th
Easily Distracted										
Freq. Refocuses										
Anger Issues										
Defiant Behavior										
Problems w/ Reading										
Problems w/ Math										

- Has your child every been in any type of special education program?

1. Infant-Toddler or Birth-3 Program: ___ No ____ Yes (How Long?_____)
2. Learning Disabilities: ____ No ____ Yes (How Long?_____)
3. Behavioral Classes: ____ No ____ Yes (How Long?_____)

4. Speech/Language Therapy: ____ No ____ Yes (How Long?_____)
5. Friendship Room: ____ No ____ Yes (How Long?_____)

- Has the child ever been

1. Suspended from school: ____ No ____ Yes Number of Suspensions_____

Why?_____

2. Expelled from School: ___ No ____ Yes Number of Expulsion_____

Why?_____

3. Held back in schoool ____ No ____ Yes If yes, Why?_____

_____

- Development normal for age? ____ Yes _____ No (Please Explain) _____

_____

Current School Information

- Current Grade Level:_____
- Current School: _____
- Current Teacher:_____

- Does you child currently have and IEP or 504: _____IEP _____504

If yes,Why?_____

- What behaviors in the classroom are of concern?_____

  _____

  _____
- How frequently does child receive refocus slips?_____
- What modification has been attempted in he classroom?_____

_____

_____

Behavioral Concerns

	Yes	No		Yes	No
Fidgets			Often loses temper		
Difficult remaining seated			Often argues with adults		
Difficulty waiting turn			Often blames other for own mistakes		
Difficulty following instruction			Is easily annoyed by others		
Shifts from one activity to another			Is often angry or resentful		
Difficulty playing quietly			If often revengeful		
Often Talks excessively			Often swears or uses obscene language		
Often interrupt or intrudes on others			Often actively defies or refuses adults requests or rules		
Often engages in physically dangerous activity			Often deliberately does things that annoy other people		
Often does not listen					
Often loses things					

	Yes	No		Yes	No
Steals			Depressed moods most days		
Has run away			Irritable moods most days		
Has run away over night			Diminished pleasure in activities		
Lies often			Increased appetite		
Deliberate fire-setting			Decreased appetite		
Miss school frequently			Problem sleeping		
Breaking and entering			Excessive sleeping		
Destroyed others property			Suicidal Ideation		
Cruelty to animals			Suicidal attempts		
Forced someone else to be sexually active			Self harm		
Used a weapon in a fight					
Often initiates physical fights			Frequent c/o of illness (ie. Headaches or stomach aches)		
Physically cruel to people			Self-conscious		
			Inability to relax		
Excessive reaction to noise			Persistent school refusal		
Fails to react to loud noise			Refusal to sleep alone		
Overreacts to touch			Persistent avoidance of being alone		
Compulsive rituals			Repeated night mares about separation		
Motor tics			Distress related to Separation from home		
Vocal tics			Distress related to separation from parent		
Unusual fears			Panic Attacks		
Strange aversions to food or textures			Excessive need for reassurance		
			Anxious		
			Worries alot		
			Nervous