R. PATRICK SAVAGE, JR., PH.D., ABMP & Associates
6010 Executive Blvd., Suite 1030
North Bethesda, MD 20852
Psychologist: MD# 2219

17101 Thatcher Court
Olney, MD 20832
Telephone 301-587-2818

www.olneynorthbethesdapsychology.com

CHILD/ADOLESCENT INTAKE FORM

The following information is requested so that I may provide you with the best service possible. This information is confidential and shall be protected as such. For a summary of how I provide psychological/counseling services, please read the Office Policies and Procedures provided to you.

CHILD INFORMATION

Child's name _____ Birth date___/___/___ Birth Country_____ Age_____ Sex_____ Today's Date___/___/___
Last First Middle

_____
Home Address City State Zip

Person filling out this form: G Mother G Father G Stepmother G Stepfather G Other:_____

Child's school_____
Name Address Grade Teacher Phone Number

Home Phone _____ Father's Phone O: _____ C: _____ Mother's Phone O: _____ C:_____

Father's E-mail for confidential communication_____Mother's E-mail for confidential communication_____

Child's Primary Language _____ Child's Secondary Language _____ If not English age learned_____

Purpose of consultation (brief summary of the main problems):_____
_____
_____
_____
_____

Date of onset of problems: ____/____/____ Date of accident: ____/____/____ Date of injury: ____/____/____

What specific questions or goals do you have for the evaluation or for counseling:
1._____ _____

2._____

3._____ _____

4._____

I would like or have been referred for: G Counseling G Evaluation G Psychological Testing G Neuropsychological Testing G Unsure

Person/s who referred you:_____ Child's Physician:_____
Name Tel # Name Tel#

Medical Specialists: _____ May I contact your child's physician to coordinate care: G Yes G No
_____

FAMILY INFORMATION

Marital status of biological parents: G Married G Separated G Divorced G Widowed G Other _____
If separated or divorced: How old was child when separated? ____ divorced? ____ Who has legal custody G Mother G Father G Joint

Please list all additional members of your child's immediate family including yourself:

Name	Relationship	Age	Birth Date	Highest Grade Comp.	Occupation

DEVELOPMENTAL HISTORY

{Please check all items that apply}

PREGNANCY

G Excessive vomiting_____ G Hospitalization required_____
G Excessive staining or blood loss_____ G Threatened miscarriage_____
G Infection(s) (specify)_____ GToxemia/Preeclampsia_____
G Operation(s) (specify)_____ G Other illnesses) (specify)_____
G Medications taken _____ G X-ray studies_____
G Smoking :Ave cigarettes per day_____ G Alcoholic consumption beyond an occasional drink_____
G Drug Use:_____ Activity level of fetus while in utero: G High G Medium G Low

DELIVERY

Type of labor: G Spontaneous G Induced G Emergency Length of Pregnancy_____ Birth Weight_____
Type of delivery: GHeadfirst G Breech G Extremities G Cesarean_____
Forceps: Ghigh_____ G mid _____ G low_____ Suction G Yes G No Duration of labor hours_____
G Cord around neck_____ G Cord presented first_____
G Hemorrhage_____ G Fetal distress _____
G Placenta Previa_____ G Other_____

POST-DELIVERY PERIOD (while in the hospital)

Respiration: G Immediate_____ G Delayed (if so, how long)_____
G Cyanosis (turned blue)_____ G Mucus accumulation_____
G Ingested Meconium_____
G Jaundice G Treated with Bilirubin (blue) lights Length of treatment_____
G Rh factor G Transfusion G Injection_____
APGAR scores at delivery (if known): at 1 minute_____ at 5 minutes_____ Number of days baby in the hospital Post delivery_____
G Incubator care Number of days_____ For what_____
G Intensive Care Number of days_____ For what_____
G Initial Feeding Difficulties_____ G Infection (specify)_____
G Vomiting_____ G Diarrhea_____
G Seizures_____ G Birth defects (specify)_____

INFANCY-TODDLER PERIOD

Were any of the following present, to a significant degree, during the first few years of life? If so, describe.

G Did not enjoy cuddling_____ G Was not calmed by being held and/or stroked_____
G Colic_____ G Excessive restlessness_____
G Diminished sleep because of restlessness and easy arousal G Frequent head banging_____
G Toe Walking_____ G Arm flapping_____
G Excessive preoccupation with objects or parts of objects etc. G Constantly into everything_____
G Excessive number of accidents compared to other children G Frequent trips to emergency room_____
G Unusually quiet and inactive_____ G Not Alert_____
Please describe basic temperament_____

_____

_____

DEVELOPMENTAL MILESTONES

If you can recall, check the age at which your child demonstrated the following behaviors.

	Early	Average	Late	Never
Smiled	G	G	G	G
Rolled Over	G	G	G	G
Sat Alone	G	G	G	G
Crawled	G	G	G	G
Stood without support	G	G	G	G
Walked without assistance	G	G	G	G
Ran	G	G	G	G
Fed Self	G	G	G	G
Rode tricycle	G	G	G	G
Rode bike (w/out training wheels)	G	G	G	G
Buttoned clothing	G	G	G	G
Tied shoelaces	G	G	G	G

	Early	Average	Late	Never
Colored in between lines	G	G	G	G
Printed letters	G	G	G	G
Wrote in cursive	G	G	G	G
Babbled	G	G	G	G
First words besides "ma-ma" and "da_da"	G	G	G	G
Said phrases	G	G	G	G
Said sentences	G	G	G	G
Said alphabet in order	G	G	G	G
Began to read	G	G	G	G
Bowel trained, day	G	G	G	G
Bowel trained, night	G	G	G	G
Bladder trained, day	G	G	G	G
Bladder trained, night	G	G	G	G

COORDINATION

Rate your child on the following skills:

	Good	*Average*	*Poor*
Walking	G	G	G _____
Running	G	G	G _____
Throwing	G	G	G _____
Catching	G	G	G _____
Bike Riding	G	G	G _____
Athletic ability	G	G	G _____
Shoelace tying	G	G	G _____
Buttoning	G	G	G _____
Writing	G	G	G _____

CHILD'S MEDICAL HISTORY

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

G Childhood diseases (describe any complications)_____

G Hospitalizations for illnesses) other than operations_____

G Surgery_____

G Head injuries G with unconsciousness_____ G without unconsciousness_____

G Sports concussion/removed from play_____

G Involved in automobile accident_____

G Convulsions G with fever_____ G without fever_____

G Coma_____

G Meningitis or encephalitis_____

G Immunization reactions i.e., DPT_____

G Persistent high fevers _____ G Highest temperature ever recorded_____

G Vision problems_____ Date of last exam_____

G Wears Glasses/Contacts/Surgical Correction_____

G Hearing problems_____Date of last exam_____

G EU Tubes_____

G Poisoning_____

PRESENT MEDICAL STATUS

G Present illness(es) for which child is being treated_____

_____

_____

G Allergies_____

G Drinks Alcohol_____

G Uses Drugs i.e., marijuana, cocaine, pcp, etc._____

Medication	Reason Taken	Dose	Start Date

MENTAL HEALTH HISTORY

(Please indicate with whom, period of time, and outcome)

G Treated on an OUTPATIENT basis for Emotional or Behavioral Difficulties:

Reason Treatment Sought	Provider	Dates of Treatment	Outcome

G Previous Evaluations (Under Type please indicate Psychiatric, Psychological, Neuropsychological, Education, Speech, OT etc.:

Reason Sought	Type	Evaluator	Date

G Treated on an INPATIENT basis for Emotional or Behavioral Difficulties:

Reason Treatment Sought	Provider	Dates of Treatment	Outcome

G Currently prescribed Medication for Emotional or Behavioral Difficulties:

Medication	**Reason Taken**	**Dose**	**Start Date**

G Has experienced or witnessed traumatic event/s _____
_____
_____

G Has been or suspect emotional, physical, or sexual abused/molested: _____
_____
_____

G There are firearms in our home _____
_____

G My child has access to firearms_____

G My child has been trained in the use of firearms_____

FAMILY HISTORY - BIOLOGICAL MOTHER

Age at time of pregnancy with client_____ G Previous pregnancies: # of_____ G spontaneous abortions(miscarriages): # of_____
G Induced abortions: # of_____ G Sterility problems (specify)_____
G School: Highest grade completed_____ G Learning problems (specify)_____
G Behavior problems (specify)_____
G Medical problems (specify)_____
G Emotional Problems (specify)_____
G Neurological problems (specify)_____
G History of alcohol abuse (specify)_____
G History of drug use (specify)_____
G Have any of your blood relatives (not including client and/or siblings) ever had problems similar to those your child has? If so, describe:_____
_____

FAMILY HISTORY - BIOLOGICAL FATHER

Age at the time of the client's conception_____
G School: Highest grade completed_____ G Learning problems (specify)_____
G Behavior problems (specify)_____
G Medical problems (specify)_____
G Emotional Problems (specify)_____
G Neurological problems (specify)_____
G History of alcohol abuse (specify)_____
G History of drug use (specify)_____
G Have any of your blood relatives (not including client and/or siblings) ever had problems similar to those your child has? If so, describe:_____
_____

FAMILY HISTORY-SIBLINGS

(Please provide a brief description)

Name/Relationship	Age	Medical, Social, Academic, or Behavioral Problems

COGNITIVE SKILLS

Please rate your child's cognitive skills relative to other children of the *same age*.

	Above Average	**Average**	**Below Average**	**Severe Problem**
Intelligence	G	G	G	G
Speech Reception	G	G	G	G
Speech Production	G	G	G	G
Difficulties Reading	G	G	G	G
Difficulties Producing Written Work	G	G	G	G
Attention Span	G	G	G	G
Impulse Control	G	G	G	G
Starting Tasks	G	G	G	G
Organizational skills	G	G	G	G
Planning skills	G	G	G	G
Ability to hold information in mind	G	G	G	G
Understanding Concepts	G	G	G	G
Problem Solving Ability	G	G	G	G
Memory for Events	G	G	G	G
Memory for Facts	G	G	G	G
Ability to learn from experience	G	G	G	G

SCHOOL HISTORY

Rate your child's school experiences related to ***academic learning*** and describe any academic/behavioral difficulties:

	Above Average	**Average**	***Below Average***
Preschool	G	G	G_____
Kindergarten	G	G	G_____
1st grade	G	G	G_____
2nd grade	G	G	G_____
3rd grade	G	G	G_____
4th grade	G	G	G_____
5th grade	G	G	G_____
Middle Sch	G	G	G_____
Jun High Sch	G	G	G_____
High Sch	G	G	G_____

Current Grade Point Average (If applicable) _____

To the best of your knowledge, at what grade level is your child functioning:

	Above Grade Level	**At Grade Level**	**Below Grade Level**
Reading	G	G	G
Spelling	G	G	G
Arithmetic	G	G	G
Written Expression	G	G	G

If below grade level, please describe difficulties_____

_____

_____

G Repeated a grade. If so, when & why_____

G Regular class placement G Advanced classes i.e., honors G Skipped a grade. If so, when & why_____

G IEP If so why, and what for_____

G 504 Plan If so what accommodations_____

G Special class/school placement (specify)_____

G Resource assistance (specify level and type)_____

Describe briefly any academic school problems that would help me to understand your child_____

_____

_____

_____

Does your child's teacher describe any of the following as significant classroom problems?

G Doesn't sit still in his or her seat
G Shouts out
G Won't wait his or her turn
G Does better in 1-to-1 relationship
G Doesn't pay attention
G Doesn't listen when spoken to
G Doesn't hear instructions
G Often unprepared for tasks
G Easily distracted from task
G Frequently gets up and walks around the classroom
G Doesn't wait to be called upon
G Does not cooperate well in group activities
G Doesn't respect the rights of others
G Makes careless mistakes
G Fails to finish work
G Difficulty organizing desk, notebook or work area
G Often loses things necessary for tasks
G Often forgetful of daily activities

Describe briefly any <u>other</u> classroom behavioral problems_____

_____

_____

_____

PEER/SOCIAL RELATIONSHIPS

G My child seeks friendships with peers
G Socializes with peers own age
G Socializes with younger peers
G My child is sought after by others for friendships
G Socializes with older peers
G Participates in after school activities ie: clubs, scouts, church/synagogue org., youth grps.

Primary group my child socializes with G adults G older G same age G younger

G Peer group has changed significantly in last year or two_____

_____

Describe briefly any problems your child may have with peers_____

_____

_____

_____

HOME BEHAVIOR

All children exhibit, to some degree, the kinds of behavior listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her age.

G Hyperactivity (high activity level)
G Impulsivity (poor self control)
G Temper outbursts
G Interrupts frequently
G Acts like he or she is driven by a motor
G Excessive number of accidents
G Poor memory
G Difficulty sitting still when being read to
G Difficulty or cannot follow 2 & 3 step directions.
G Wears out shoes more frequently than siblings
G Poor attention span
G Low frustration tolerance
G Sloppy table manners
G Doesn't listen when being spoken to
G Heedless to danger
G Doesn't learn from experience
G More active than siblings
G Easily distracted
GSudden outbursts of physical abuse of other children

INTERESTS AND ACCOMPLISHMENTS

What are your child's main hobbies and interests?_____
_____
What are your child's areas of greatest accomplishment?_____
_____
What does your child enjoy doing most?_____
_____
What does your child dislike doing most?_____
_____
What are your child's greatest strengths?_____
_____

PROBLEM CHECKLIST

Most children exhibit, at one time or another, one or more of the symptoms listed below. Only mark those symptoms that have been present to a significant degree over a period of time.

Past	Current		Past	Current	
G	G	Stuttering	G	G	Lack of interest in others
G	G	Recoils for affectionate physical contact	G	G	Mute (refuse to speak when able)
G	G	Compulsive repetition of seemingly meaningless physical actions	G	G	Speech non-communicative or poorly communicative
G	G	"Gets Hooked" on certain ideas and remains preoccupied			
G	G	Violent outbursts of rage	G	G	Doesn't respect the rights of others
G	G	Stealing	G	G	Truancy from school
G	G	Cruelty to animals, children, and others	G	G	Runs away from home
G	G	Trouble with police	G	G	Selfish
G	G	Fire setting	G	G	Violent assault
G	G	Excessively taunts other children	G	G	Destruction of property
G	G	"Wise Guy" or smart aleck attitude	G	G	Egocentric (self centered)
G	G	Doesn't know when to stop	G	G	Frequently hits other children
G	G	Too mature, frequently acts older than actual age	G	G	Brags/Boasts
			G	G	Often cheats when playing games
G	G	Little/no guilt over behavior that causes pain/discomfort	G	G	"Sore Loser"
			G	G	Typically wants his/her own way
G	G	Little/no response to punishment for antisocial behavior	G	G	Often appears insincere or artificial
			G	G	Forced sex on another child/adolescent
G	G	Wants things own way with exaggerated reaction if thwarted	G	G	Trouble putting self in other person's position

Past	Current		Past	Current	
G	G	Frequent use of profanity to parents, teachers and other authorities	G	G	Negativistic (does opposite of requests)
G	G	Quietly/softly defiant of authority	G	G	Feigns/verbalizes compliance or cooperation but doesn't comply with requests
G	G	Argumentative			
G	G	Blatantly uncooperative			
G	G	Obstructionistic			
G	G	Excessively critical of others	G	G	Frequent temper tantrum
G	G	Very poor toleration of criticism	G	G	Open defiance of authority
			G	G	Ever trying to avoid responsibility
			G	G	Very stubborn
G	G	Constant throat clearing	G	G	Feelings easily hurt
G	G	Tics (i.e., eye blinking, grimacing or other spasmodic repetitious movements)	G	G	Eats non-edible substances
			G	G	Involuntary grunts/vocalizations (understandable or not)
G	G	Encopresis (soiling)	G	G	Constipation
G	G	Preoccupation with bowel movements	G	G	Frequent stomach cramps
G	G	Enuresis (daytime bed wetting)	G	G	Enuresis (nighttime bed wetting)
G	G	Frequent head/stomach aches etc., when away from parents	G	G	Excessive worry of loss of a parent
			G	G	Excessive worry of being lost
G	G	Excessive distress when separated from parent	G	G	Reluctance to go to school
G	G	Excessive worry of harm to a parent	G	G	Nightmares of parental loss/harm
G	G	Reluctance to alone without a parent	G	G	Very tense
G	G	Reluctance to go to sleep without a parent near by	G	G	Insomnia (difficulty falling asleep)
			G	G	Frequent nausea/vomiting
G	G	Excessive guilt over minor indiscretions	G	G	Irritability, easily "flies off the handle"
Fears					
G	G	Dark	G	G	New situations
G	G	Strangers	G	G	Being alone
G	G	Death	G	G	Visiting other children's homes
G	G	School	G	G	Animals
G	G	Other fears_____	G	G	Going away to camp
Anxiety					
G	G	Anxiety attacks with palpitations (heart pounding), shortness of breath, sweating, etc.	G	G	Frequent nightmares
			G	G	Night terrors (terrifying night-time outbursts)
G	G	Often complains of body aches/pains	G	G	Sleepwalking
G	G	Nail biting, chews clothes, blankets, etc.	G	G	Worries over body illness
G	G	Hair pulling with hair loss	G	G	Head banging
G	G	Perfectionistic, rarely satisfied with performance	G	G	Picks on skin
G	G	Low self-esteem	G	G	Excessive self criticism
G	G	Depression	G	G	Frequent crying spells
G	G	Suicidal preoccupation, gestures, attempts	G	G	Frequently feeling worthless
G	G	Suicidal thoughts	G	G	Poor motivation
G	G	Loss of interest in activities	G	G	Apathy
G	G	Little concern for personal appearance hygiene	G	G	Low energy level
G	G	Little concern/pride for personal property	G	G	Awakens in the middle of the night and has trouble falling asleep
G	G	Excessive sexual interest/preoccupation	G	G	Frequent sex play with other children
G	G	Frequently likes to wear clothing of the opposite sex	G	G	Excessive masturbation
			G	G	Exhibits gestures/intonations of the opposite sex

Past	Current		Past	Current	
G	G	Eating binges with overweight	G	G	Eats large amounts, then vomits or uses laxatives
G	G	Preoccupied with being overweight	G	G	Overeating with overweight
G	G	Dissatisfaction with appearance and body parts	G	G	Preoccupied with food
G	G	Long periods of dieting/food abstinence with underweight	G	G	Under eating with underweight
G	G	Few if any friends	G	G	Doesn't seek friendships
G	G	Rarely sought by peers	G	G	Not accepted by peer group
G	G	Poor common sense in social situations	G	G	Ever complaining is often picked on and easily bullied by other children
G	G	Drug abuse	G	G	Alcohol abuse
G	G	Excess modesty over bodily exposure			
G	G	Fears asserting self	G	G	Shy
G	G	Frequently pouts and/or sulks	G	G	Withdrawn
G	G	Allows self to be easily taken advantage of	G	G	Gullible and/or naive
G	G	Inhibited self expression in dancing, singing, laughing, etc.	G	G	Inhibits open expression of anger
G	G	Passive and easily led	G	G	Excessive silliness/clowning
G	G	Excessive demands for attention	G	G	Overly dependent
G	G	Thumb-sucking	G	G	Cries easily and frequently
G	G	Baby talk	G	G	Generally immature
			G	G	Excessive desire to please authority
			G	G	Asks to be punished
			G	G	"Too good"
G	G	Suspicious/distrustful	G	G	Aloof
G	G	Feels others are persecuting him/her when there is no evidence for such	G	G	Disorganized speech
G	G	Often feels cheated/gypped	G	G	Sees visions
G	G	Speaks rapidly and under pressure	G	G	Disorganized behavior
G	G	Hears voices when no one is speaking	G	G	Inappropriate emotional reactions
G	G	Excessive fantasizing, "lives in his/her own world"	G	G	Flat emotional tone
			G	G	Development of delusions, i.e., belief system that does not make sense

Please indicate how your child's problems are affecting any of the following areas of his/her life–check and provide a brief explanation.

G School _____

G Social Relationships _____

G Family Relationships _____

G Emotional Adjustment _____

G Physical Health _____

G Community/Legal _____

G Spiritual _____

Additional Remarks– Please use the remainder of this page to write any additional comments you wish to make regarding your child: