JULIA BARRY
PSYCHOTHERAPY

Child and Family Intake (Children 12 and under):

Date:_____

Child's Name: _____Date of Birth: _____Age: ___

Parent 1's Name: _____Age: _____ Occupation:_____

Parent 2's Name: _____ Age: _____ Occupation: _____

Marital Status: _____ Home Phone: _____

Parent 1's Cell phone:_____ Parent 2's Cell phone:_____

Parent 1's Work phone:_____ Parent 2's Work phone:_____

Emergency Contact (Name & Phone): _____

Is it okay to leave a message at all these numbers? Yes:___ If not, which if any? _____

Sibling's Name: _____ DOB: _____ Age: _____

Sibling's Name: _____DOB: _____ Age: _____

What concerns if any do you have about your child? _____
_____
_____

What have you done to address the concern(s) so far?
_____
_____

Have any professionals been consulted (include any previous assessments, reports, etc.):
_____

Primary Pediatrician: _____

Developmental Pediatrician: _____ Phone: _____

Neurologist: _____ Phone:_____

Other: _____
_____
_____

Developmental History:

Adoption:
Is your child adopted? Does he or she know they are adopted?_____

Pregnancy and Delivery:
Length: _____ months? Was the timing of the pregnancy good for you? _____

Any complications during pregnancy? _____

Any medications taken during pregnancy? _____

How did you feel about the pregnancy? _____

How did your Partner/spouse feel about the pregnancy? _____

What was your mood during pregnancy? _____And after? _____

Type of delivery? _____ Birth Weight? _____Complications? _____

Emotional reaction to child? _____

Baby's temperament? _____

Breast-fed? _____ Bottle-fed? _____How did weaning go? _____

Problems with feeding? _____ Problems with sleeping? _____

Problems in the marital relationship? _____

Developmental Milestones:
Sat up at _____ Crawled at _____Walked at_____

JULIA BARRY
PSYCHOTHERAPY

First words_____ Spoke in sentences_____

Toilet training accomplished (yes/no) _____at_____ Difficulties? _____

Medical History:
Chronic Illness_____ Hospitalization_____ Surgeries_____

Ear infections _____ Strep _____ Allergies_____ Asthma_____

Other_____

Family History:
Have any immediate or extended family members experienced any of the following:
(Circle all that apply)
Anxiety Bi-Polar Disorder

Depression ADD/ADHD

Alcohol/Substance Abuse Schzophrenia/Psychotic Disorder

Childcare or Preschool:
Preschool_____Telephone_____Director_____

Teacher_____Time/Days_____

Age started_____ Reaction to separation/and process_____
_____

Relationship with teachers/caregivers _____With other children_____

Concerns of teachers/caregivers_____

General:
Does your child either seek-out, avoid, or over-react to: noises? ____ bright lights? _____

touch ? _____ smells? _____ food textures?_____ clothing?_____

movement?_____

Have there been any long separations, losses, exposure to extreme family conflict or traumas, etc. in your child's life? Please describe: _____
_____

Please describe your child's personality: _____
_____

Please describe your child's relationship to you:
Parent 1_____
_____

Parent 2_____
_____

Describe your parenting style. What is your attitude toward discipline and structure?
Parent 1_____
_____

Parent 2_____
_____

Describe your comfort level with an expression of a range of feelings:
Parent 1_____
_____

Parent 2_____
_____

How well do you and your partner co-parent together?
Parent 1_____
_____

Parent 2_____
_____

What does your child like to do? _____
_____
_____

JULIA BARRY
PSYCHOTHERAPY

What does you child not like to do? _____
_____

Describe your child's ability to handle:
Separations _____

New situations and people_____

Frustration_____

Limit Setting_____

Transition times_____

Expressing him/herself emotionally _____

Soothing him/herself _____

Recovery from distress _____

Self-Care (dress, feed, brush teeth, use toilet, etc.)_____

Do you have concerns in the following areas:
Making eye contact _____

Answering to his/her/their name_____

Arching back when being held_____

Excessive crying_____

Not pointing or mutually engaging_____

Fine motor skills _____Gross motor skills_____

Sleeping_____

Eating_____

Aggression _____

Behavioral concerns _____

Temper tantrums _____

Social interactions with peers_____

Social interactions with adults_____

Passivity or lack of interest in things_____

Other _____

At approximately what age did your child begin to…Point at things_____

Coo and babble_____ First words _____ Name things_____

Combine two words _____Use short sentences_____

Ask questions _____ Answer questions_____

Imitate movements _____ Identify needs_____

Please describe your child's feeding and eating development (picky eater, aversions, chewing or swallowing difficulties or allergies):

_____

_____