Intake Information for Children's Hospital Department of Psychology

Thank you for completing the following questions. This information is confidential and will not be released without your permission.

BASIC INFORMATION ABOUT CHILD

Name Jeffrey Bodin

Today's Date 2019-11-08

Gender (Male) Female Age 22

Child's Birthdate 1997-05-22

Race/Ethnicity (White (Caucasian)) Black (African American)
Hispanic / Latino Asian / Pacific Islander
American Indian / Aleut / Eskimo Other

Current School N/A

Parish St. Tammany Grade N/A

BASIC INFORMATION ABOUT CAREGIVER(S)

Legal Guardian Name N/A

Relation to Child

Home Address 520 Bear Chase Dr

Home Phone

Work Phone

Parish St. Tammany

Person completing this form Parent

Who referred you here? Oncology / Dr. Lobbel Title

Address CHNO HELNOC Phone

PRESENTING PROBLEMS

Briefly describe your child's current difficulties

How long has this problem been a concern for you?

When did you first notice the problem?

Do any family members have similar problems? Yes No If yes, whom?

DEVELOPMENTAL HISTORY

PREGNANCY

Duration of pregnancy (weeks or months) Premature

During the pregnancy did the mother

- ✓ Suffer from illness or disease C-Section?
- ___ Undergo surgery
- ___ Take medication Counts??
- ___ Have X-rays
- ___ Use tobacco/smoke cigarettes
- ___ Use alcohol
- ___ Use drugs
- ___ Suffer from an accident

Complications of this pregnancy included

- ___ Excessive vomiting
- ___ Excessive staining or blood loss
- ___ Threatened miscarriage/premature labor
- ___ Infection(s)
- ___ Toxemia
- ___ Diabetes
- ___ High blood pressure
- ___ Poor nutrition
- ___ Amniocentesis
- ___ Loss of consciousness in mother

DELIVERY

Duration of Labor _____ hours Birth Weight _____ Length _____

Type of Labor Spontaneous Induced Type of Delivery Normal Cesarean Breech

Complications

- ___ None
- ___ Cord around neck
- ___ Problems with placenta
- ___ Hemorrhage
- ___ Delay in breathing
- ___ Injury to infant
- ___ Other (describe _____)

NEWBORN and POST-DELIVERY PERIOD

Was your baby in the Neonatal Intensive Care Unit (NICU)? (Yes) No If yes, how long? _____

Total days baby was in the hospital after delivery _____

Complications

- ___ None
- ___ Addiction
- ___ Anemia
- ___ Diarrhea
- ___ Jaundice (yellow skin)
- ___ Infection
- ___ Seizures
- ___ Vomiting
- ___ Intraventricular hemorrhage
- ___ Meconium staining or aspiration
- ___ Needed respirator/resuscitation
- ___ Cyanosis (turned blue)

INFANCY and TODDLER PERIOD

As a baby, the child was

- ___ Active
- ___ Cranky
- ___ Calm
- ___ Difficult
- ___ Easy
- ___ Happy
- ___ Shy
- ___ Sleepy
- ___ Social
- ___ Hard to please
- ___ Lazy or slow moving
- ___ Persistent

Were any of the following present in the first five years of life?

_____ Colic
_____ Difficulty sleeping
_____ Feeding problems
_____ Frequent headbanging
_____ Excessive restlessness
_____ Did not enjoy cuddling
_____ Constantly into everything
_____ Temper tantrums
_____ Clingy or difficulty separating from caregivers
_____ Slow or unable to adapt to changes in routines
_____ Excessively **high** or **low** activity level (circle one)
_____ Not calmed by being held and/or stroked
_____ Excessive number of accidents compared to other children
_____ Withdrawal or other problems adjusting to new people or situations
_____ Variable or irregular body functions (sleep, hunger, bowel movements, etc.)
_____ Reaction to or allergy to the DPT shot or pertussis vaccine

Were there any special problems in the development of the child during the first years? Yes (No)

If yes, please describe _____

_____

_____

DEVELOPMENTAL MILESTONES

Please indicate the age at which your child first demonstrated each of the following behaviors. If you are unsure, please write a question mark.

Behavior	Age
Sat up unassisted	?
Walked alone	?
Spoke first word	?
Put several words together	?
Became toilet trained (bladder)	?
Became toilet trained (bowel)	?
Stayed dry at night	?
Fed self with fork or spoon	?
Rode tricycle	?

Compared to other children, how do you view your child's development? (Normal) Delayed Advanced

MEDICAL HISTORY

Please place a check next to any illness or condition that your child has. Please also note the date or child's age at the time of the illness.

	Illness or Condition	Age/Dates		Illness or Condition	Age/Dates
	AIDS or HIV positive		✓	Headaches	10 yrs/2008
	Allergies			Heart problems/disease	
	Anemia			Heavy metal poisoning	
	Aneurysm			Hepatitis	
	Anoxia			Herpes	
	Arteriovenous malformation			High blood pressure	
	Arthritis			Jaundice	
	Asthma			Leukemia	
✓	Ataxia			Malnutrition	
	Automobile accident	7 yrs/2005		Meningitis	
	Back pain/problems			Muscular disease	
	Bleeding problems			Pain problems	
	Blood disorders			Paralysis	
	Bone or joint disease			Pituitary disorder	
✓	Broken bones			Pneumonia	
✓	Cancer	10 yrs/2006		Poisoning	
	Coma			Rheumatic fever	
	Cystic Fibrosis			Scarlet fever	
	Dazed or unconscious			Sensory losses	
	Dementia			Sexual molestation	
	Diabetes			Speech/language problems	
	Dysarthria			Spells (_____)	
✓	Dyspraxia or Apraxia			Stroke	
✓	Ear infections (PE tubes)	3 + 4 yrs/2000		Suicide attempt/thoughts	
✓	Other ear problems →	2001		Sunstroke/heat exhaustion	
	Eczema or hives			Thyroid disorder/problem	
✓	Encephalitis			Trauma (_____)	
✓	~~Epilepsy~~, seizures, fits	10 yrs/2008		Tuberculosis	
	Fainting spells			Tumor	
	Fetal Alcohol Syndrome			Visual problems	
	Fever (if high or prolonged)			Whooping cough	
	Guillian-Barre Syndrome			Other medical problems:	
	Head injury				

Indicate if child has had any of these medical tests and if yes, indicate age/dates

	Electroencephalogram (EEG)		MRI scan
	Skull X-rays		Opthalmological (vision)
	CT scan		Audiological (hearing)

Has your child ever suffered from a head injury which caused confusion/loss of consciousness? Yes No

Please list any chronic/serious illnesses or operations your child has had and child's age

_____

Pediatrician's name and address _____

If your child is taking any medication other than for colds and minor infections, please list them below:

Medication	Age	Reason Prescribed	Prescriber

Did your child take his/her medications as usual on the day of the appointment with Psychology? Yes No

Has your child's hearing been evaluated? Yes No If yes, date of testing _____

If yes, type of provider who completed test (physician, audiologist) _____

Was hearing test within normal limits? Yes No

Has your child ever had a seizure? Yes No

FAMILY MEDICAL HISTORY

Please place a check next to any illness, condition, or problem experienced by any blood relative(s). When you check an item, please note the family member's relationship to the child.

Condition	Relationship to Child
_____ Alcoholism	_____
_____ Antisocial (criminal) behavior	_____
_____ Anxiety	_____
_____ Attention-Deficit/Hyperactivity Disorder (ADHD)	_____
_____ Autism Spectrum Disorder (ASD)	_____
_____ Bipolar disorder (manic-depressive disorder)	_____
_____ Depression	_____
_____ Drug addiction or drug problems	_____
_____ Head injury	_____
_____ Hyperactivity	_____
_____ Learning problems	_____
_____ Intellectual disability (mental retardation)	_____
_____ Movement disorders	_____
_____ Schizophrenia	_____
_____ Seizures, epilepsy, or convulsions	_____
_____ Sexual/physical abuse	_____
_____ Speech delays	_____
_____ Suicide or suicide attempt	_____
_____ Other (specify: _____)	_____

HOME INFORMATION

Mother's name Linda Bolin Age 52
Occupation _____ Number years of education _____

Father's name Mark Bolin Age 56
Occupation _____ Number years of education _____

Stepmother's name _____ Age _____
Occupation _____ Number years of education _____

Stepfather's name _____ Age _____
Occupation _____ Number years of education _____

If parents are separated or divorced, how old was child when the separation occurred? _____

What are the current custody/visitation arrangements? _____

Was your child adopted? Yes No Date of adoption _____ Child's age at adoption _____

Please list all people living **in** the household

Name	Relationship to Child	Age

Please list any family members (including stepfamily) who live **outside** the household

Name	Relationship to Child	Age

Who, if anyone, shares the child's room? _____

Primary language spoken in the home _____ Other languages spoken at home _____

Describe any other important information about the child's home situation _____

EDUCATIONAL HISTORY

Current School _____ Current Grade _____ Grade(s) Repeated _____

Is this school public or private? Public Private If public, which parish? _____

Teacher's Name _____ Recent Report Card Grades _____

Does/did your child attend preschool/nursery school? Yes No If yes, starting at what age _____

Does your child receive special education services? Yes No

Current educational problem areas include

_____ Reading	_____ Does not respect others' rights	_____ Cheats
_____ Math	_____ Fights with classmates	_____ Inattentive/distracted
_____ Writing	_____ Detention and/or suspension	_____ Disrupts classroom
_____ Spelling	_____ Does not like school	_____ Overactive/fidgets
_____ Other subjects	_____ Does not complete homework	_____ Poor study skills
_____ Memory problems	_____ Conflict with teacher(s)	_____ Worries about school
_____ Excessive absences	_____ Does not work well independently	

Describe any other classroom problem(s) _____

_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Has your child received any additional evaluation for your current concerns? Yes No

If yes, please list date of evaluation, outcome of evaluation, and name and type of provider who completed the evaluation (i.e., Psychologist, Neurologist, Developmental Pediatrician, Psychiatrist etc.).

Date of Evaluation	Outcome	Name and Type of Provider
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL AND BEHAVIOR HISTORY

What disciplinary techniques to you usually use with your child? Please place a check next to each technique that you usually use.

_____ Criticize child
_____ Don't use any technique
_____ Ignore problem behavior
_____ Reason with child
_____ Redirect child's interest
_____ Send child to room
_____ Scold child
_____ Spank child
_____ Other technique (describe _____)
_____ Take away some activity
_____ Take away some belongings
_____ Take away food
_____ Tell child to sit in a chair
_____ Threaten child
_____ Punish child another way (describe _____)
_____ Whip child
_____ Yell or scream at child

Which discipline techniques are usually effective? _____

For what types of problem(s)? _____

Which discipline techniques are usually ineffective? _____

For what types of problem(s)? _____

How consistent are the rules and discipline for your child? _____

What are your child's favorite activities?

1. _____ 2. _____ 3. _____

What activities does your child like least?

1. _____ 2. _____ 3. _____

What are your child's strengths? _____

_____

Is there any additional information that you think may help us in working with your child?

_____

_____

_____

Reviewed by: Hillary Becker Date/Time 1/8/2019