Name_____ Date of Birth_____

Capital Area Pediatrics

Intake for Emotional, Behavioral or Learning Concerns Visit

Please answer the following questions prior to your child's consultation to help us focus on the issues that are most important to you. Provide details for any "yes" answers.

Describe your current concern about your child:

Grade: School:

How is your child doing in school?

What are your child's strengths?

Does your child have any emotional or behavioral issues that were not described above?

Does your child have any challenges with their peers or socializing?

Does your child have any recurring physical symptoms?

Does your child have any unusual movements or tics?

How many hours of sleep does your child usually get? Do they have any problems with sleep?

Do you have concerns about your child's eating habits?

Has your child experienced any stressful or traumatic events?

Has your child experienced thoughts of self harm, self injury or aggression?

Who does your child live with?

Does any close family member have a learning, attention, or emotional diagnosis?

Please list any prior developmental or psychological evaluations your child child has had with approximate dates and outcomes:

Has your child ever had counseling, psychiatric care, emergency mental/behavioral health evaluation or crisis intervention?

Has your child had any supports or accommodations (such as IEP or 504 Plan, speech therapy, PT, OT, ABA, tutoring) either in school or privately?

Has your child ever taken medication for mood, anxiety, attention, sleep, or behavior? If yes, please list the medications and whether they were helpful:

If you are filling this out on your computer,
please be sure to SAVE before sending this form back to us.