



Dr. Raymond M. Fuchs, Ph.D.

Suite 518 Midtown Plaza

330 W. Gray

Norman, Oklahoma

(405) 217 2964, Fax (405) 217 2408

Child Evaluation Intake Form

CHILD'S PERSONAL INFORMATION

Today's Date: _____

Child's Name: _____ M F Age: _____ Birthdate: _____

Referred by: _____ Specialty: _____

Why do you want your child evaluated? _____

CURRENT CONCERNS ABOUT YOUR CHILD

Please check all that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> aggression | <input type="checkbox"/> has few friends | <input type="checkbox"/> has no friends |
| <input type="checkbox"/> overactivity | <input type="checkbox"/> language difficulties | <input type="checkbox"/> toilet training |
| <input type="checkbox"/> preoccupations | <input type="checkbox"/> temper tantrums | <input type="checkbox"/> biting |
| <input type="checkbox"/> hitting | <input type="checkbox"/> self-injury | <input type="checkbox"/> sleep problems |
| <input type="checkbox"/> sleeps in parents' bed | <input type="checkbox"/> has nightmares | <input type="checkbox"/> nervousness |
| <input type="checkbox"/> argumentative | <input type="checkbox"/> easily distracted | <input type="checkbox"/> self-help skills |
| <input type="checkbox"/> won't take baths | <input type="checkbox"/> appetite/food selections | <input type="checkbox"/> eats things that aren't food |
| <input type="checkbox"/> wets the bed | <input type="checkbox"/> pulls out own hair | <input type="checkbox"/> inattentive |
| <input type="checkbox"/> school adjustment | <input type="checkbox"/> cruel to animals | <input type="checkbox"/> inappropriate sexual behavior |
| <input type="checkbox"/> motor skills | <input type="checkbox"/> depressed or anxious | <input type="checkbox"/> muscle tone |
| <input type="checkbox"/> self-stimulatory behaviors: rocking, spinning, flapping hands, visual scrutiny | | |
| <input type="checkbox"/> Other: _____ | | |

Please provide detail for any items checked above: _____

What is the biggest problem?

How long has it been a problem?

What do you think caused it?

What seems to upset the child?

What seems to calm the child?

CHILD'S CURRENT LIVING SITUATION

With whom does the child currently reside? (please mark all that apply)

- Biological Mother Biological Father Step-mother Step-father
- Adoptive Mother Adoptive Father Foster Mother Foster Father
- Grandparent
- Other: _____

Complete the following for the child's **BIOLOGICAL PARENTS** to the best of your ability, *even if you are not the child's biological parent.*

Biological Mother's Name: _____ Age: _____ Birthdate: _____
 Occupation: _____ Ethnic/Cultural Background: _____
 Phone: _____

Biological Father's Name: _____ Age: _____ Birthdate: _____
 Occupation: _____ Ethnic/Cultural Background: _____
 Phone: _____

If child does not live with BOTH biological parents, who has legal custody of the child? _____

If the child currently resides with parents OTHER than biological parents, please describe them here.

Parent/Caretaker One's name: _____ Age: _____ Birthdate: _____
 Relationship to child: Adoptive Parent Step-Parent Foster Parent Grandparent
 Parent's partner Other: _____
 Occupation: _____ Ethnic/Cultural Background: _____
 Phone: _____

Parent/Caretaker Two's name: _____ Age: _____ Birthdate: _____
 Relationship to child: Adoptive Parent Step-Parent Foster Parent Grandparent
 Parent's partner Other: _____
 Occupation: _____ Ethnic/Cultural Background: _____
 Phone: _____

Highest level of education by each parent:

- | Biological Mother | Biological Father | Parent 1 (above, if app.) | Parent 2 (above, if app.) |
|---|--|--|---|
| <input type="checkbox"/> 11 grade or less | <input type="checkbox"/> 11 grade or less | <input type="checkbox"/> 11 grade or less | <input type="checkbox"/> 11 grade or less |
| <input type="checkbox"/> GED | <input type="checkbox"/> GED | <input type="checkbox"/> GED | <input type="checkbox"/> GED |
| <input type="checkbox"/> High school grad | <input type="checkbox"/> High school grad | <input type="checkbox"/> High school grad | <input type="checkbox"/> High school grad |
| <input type="checkbox"/> Associates Degree | <input type="checkbox"/> Associates Degree | <input type="checkbox"/> Associates Degree | <input type="checkbox"/> Associates Degree |
| <input type="checkbox"/> Bachelor's Degree | <input type="checkbox"/> Bachelor's Degree | <input type="checkbox"/> Bachelor's Degree | <input type="checkbox"/> Bachelor's Degree |
| <input type="checkbox"/> Graduate/Professional | <input type="checkbox"/> Graduate/Profess. | <input type="checkbox"/> Graduate/Profess. | <input type="checkbox"/> Graduate/Professional |
| <input type="checkbox"/> Vocational Certificate | <input type="checkbox"/> Vocational Cert. | <input type="checkbox"/> Vocational Cert. | <input type="checkbox"/> Vocational Certificate |

How often does the other biological parent see this child? _____

Number of years married/together: _____ Approximate date of divorce/separation: _____
 Number of times married: Mother _____ Father _____
 If child is with ADOPTIVE parent, age child was first in home: _____ Date of legal adoption: _____
 What has the child been told about the adoption? _____

If your child spends a significant amount of time with a caregiver other than someone described above (i.e., spends more than 4 hours/day) EXCLUDING school personnel, please complete the following information for that person here:

Name: _____ Age: _____ Birthdate: _____
 Relationship to Child: _____ Ethnic/Cultural Background: _____
 Occupation: _____ Highest Level of Education: _____

Siblings: (please list whether the siblings live in the child's home or not)

Name	Age	M/F	Full/Step/Half?	Grade	In child's home?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Other occupants of child's residence NOT listed above: _____
 What languages does the child use (List PRIMARY language first): _____
 What other languages is your child exposed to? _____

DEVELOPMENTAL HISTORY

Prenatal/Pregnancy

Did the biological mother have any of the following immediately before/after or during pregnancy?

- Maternal injury. Describe: _____
- Hospitalization during pregnancy. Reason: _____
- X-rays during pregnancy. What month of pregnancy? _____

Did the biological mother have any of the following during pregnancy?

- | | | |
|--|---|---|
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Infections | <input type="checkbox"/> Premature Labor |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Bed-rest | <input type="checkbox"/> Toxemia |
| <input type="checkbox"/> Difficulty in conception | <input type="checkbox"/> Anemia | <input type="checkbox"/> Gained more than 35 pounds |
| <input type="checkbox"/> Excessive swelling | <input type="checkbox"/> Vaginal bleeding | <input type="checkbox"/> Measles/German measles |
| <input type="checkbox"/> Excessive nausea/vomiting | <input type="checkbox"/> Flu | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Threatened miscarriage |
| <input type="checkbox"/> Rh incompatibility | <input type="checkbox"/> Headaches | <input type="checkbox"/> Severe cold |
| <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Other virus | |
| <input type="checkbox"/> Special diet, describe: _____ | | <input type="checkbox"/> Meds: _____ |
| <input type="checkbox"/> Other: _____ | | |

Mother's age at conception: _____

Did the mother have previous pregnancies? No Yes

how many, including miscarriages? _____

Did mother receive prenatal care during this pregnancy? No Yes--beginning at month _____

During the pregnancy, was the baby: Very active Average Rather quiet

Were there any unusual changes in the baby's activity level during pregnancy? No Yes

Delivery

Was infant born full-term? Yes No

If premature, how early? _____ If overdue, how late? _____

Birth weight: _____

Type of anesthetic used: None Spinal Local General

Length of active labor: _____ Describe any complications during delivery: _____

Check all of the following that applied to the delivery:

- Spontaneous Breech Forceps
- Head first Multiple births Cord around neck
- Induced; Reason: _____
- Cesarean; Reason: _____

Which of the following applied to the infant? (check all that apply)

- Breathing problems Required oxygen Required incubator
- Jaundice (Were Bilirubin lights used?) Feeding problems Sleeping problems
- Infection Rash Excessive crying
- Seizures/convulsions Unusual appearance, describe: _____
- Bleeding into the brain

Did the infant require: X-Rays CT scans Blood transfusions

Placement in the NICU (If so, for how long? _____)

Length of stay in hospital: Mother _____ Infant _____

Early Childhood History

During this child's first three years, were any special problems noted in the following areas?

- Irritability Breathing problems Colic
- Difficulty sleeping Eating problems Temper tantrums
- Failure to thrive Excessive crying Withdrawn behavior
- Poor eye contact Early learning problems Destructive behavior
- Convulsions/Seizures Twitching Unable to separate from parent
- Other _____

Milestones - Indicate age when child:

_____ sat unaided _____ crawled _____ walked
 _____ started solid foods _____ fed self with spoon _____ gave up bottle
 _____ bladder trained-day _____ bladder trained-night _____ bowel trained
 _____ rides tricycle _____ rides bike

Can child be described as clumsy/uncoordinated? Yes No

Having fine motor delay? Yes No

Which hand does your child use for: Writing/drawing? _____ Eating? _____ Cutting? _____

Current eating behavior: Normal Picky Eats too much Weight loss/gain

Oral Motor concerns: None Difficulty swallowing Drooling Gagging

Language development

Indicate age when child begin babbling, such as repeating syllables, in attempts to communicate:

Using single words? _____ Using phrases/short sentences? _____

Have there been any hearing concerns? No Yes Hearing testing – date? _____

Adaptive Skills

Feeds self No Yes, beginning at age _____

Dresses self No Yes, beginning at age _____

Bathes self No Yes, beginning at age _____

Helps with household chores No Yes, beginning at age _____

Knows first and last name No Yes, beginning at age _____

Says “please” and “thank you” No Yes, beginning at age _____

Able to walk up/down stairs No Yes, beginning at age _____

Has the child ever lost skills, which at one time he/she was able to perform? No Yes

If yes, please explain _____

When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?

Time out Loss of allowance/privileges Physical punishment Yelling

Ignoring Grounding Other, describe _____

Who is mainly in charge of discipline? _____

What do you find most difficult about raising your child? _____

MEDICAL HISTORY

Has your child ever had:

Head injury _____ Age _____ Describe _____

Loss of consciousness Age _____ How long? _____

Describe _____

Allergies to food/medication List: _____

Surgery - Age _____ Reason _____

Describe _____

(if more than one surgery, please list on back)

Ear Infections: Age _____ Describe _____

Ear tubes? No Yes Date of surgery _____

Is the child up to date on immunizations? Yes No, Why not? _____

Doctors seen (check all that apply)

- Pediatrician – Date of last visit: _____ Diagnosis: _____

- Developmental Pediatrician – Date: _____ Diagnosis: _____
- Neurologist – Date: _____ Diagnosis: _____
suspected seizures, describe: _____
seizures diagnosed, type: _____
- Genetics – Date: _____ Diagnosis: _____
- Psychiatry – Date: _____ Diagnosis: _____
- Psychology – Date: _____ Diagnosis: _____
- Gastroenterology – Date: _____ Diagnosis: _____
stomach/intestinal problems, type: _____
- Endocrinology – Date: _____ Diagnosis: _____

Diagnostic Testing (check all that apply)

- EEG (brain wave test) – Date: _____ Results: _____
- MRI – Date: _____ Results: _____
- CT Scan – Date: _____ Results: _____
- Ophthalmology Evaluation – Date: _____ Results: _____
- Chromosomal/DNA testing (Genetics) – Date: _____ Results: _____
- Other - Describe: _____

Medication history

CURRENT medications

Name of medication	Dose & Frequency	Date Started	Reason	Effectiveness

Who prescribes these medications? _____ Date of last visit: _____

Please also list any medications your child has been on in the PAST:

Name of medication	Dose & Frequency	Date Started/Ended	Reason	Effectiveness

Who prescribed past medications?

CHECKLIST: Please mark any of the following in each area that describe your child currently or in the past:

Speech

- | | | | | | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--|
| Past | Current | | Past | Current | |
| <input type="checkbox"/> | <input type="checkbox"/> | slow speech development | <input type="checkbox"/> | <input type="checkbox"/> | doesn't understand without gestures |
| <input type="checkbox"/> | <input type="checkbox"/> | unusual tone or pitch | <input type="checkbox"/> | <input type="checkbox"/> | repeats words/phrases over and over |
| <input type="checkbox"/> | <input type="checkbox"/> | difficult to understand speech | <input type="checkbox"/> | <input type="checkbox"/> | repeats questions, instead of answering them |
| <input type="checkbox"/> | <input type="checkbox"/> | seldom speaks unless prompted | <input type="checkbox"/> | <input type="checkbox"/> | repeats dialogue from movies/songs verbatim |
| <input type="checkbox"/> | <input type="checkbox"/> | has language of his/her own (may sound like foreign language/jargon) | | | |

Relating with other people

- | | | | | | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|-----------------------------|
| Past | Current | | Past | Current | |
| <input type="checkbox"/> | <input type="checkbox"/> | prefers to be by self | <input type="checkbox"/> | <input type="checkbox"/> | "in a world of his/her own" |
| <input type="checkbox"/> | <input type="checkbox"/> | aloof, distant | <input type="checkbox"/> | <input type="checkbox"/> | clings to people |
| <input type="checkbox"/> | <input type="checkbox"/> | fearful of strangers | <input type="checkbox"/> | <input type="checkbox"/> | not cuddly as baby |
| <input type="checkbox"/> | <input type="checkbox"/> | doesn't like to be held | <input type="checkbox"/> | <input type="checkbox"/> | doesn't recognize parent |
| <input type="checkbox"/> | <input type="checkbox"/> | doesn't play with other children | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | prefers playing with younger or older children | | | |

Imitation

- | | | |
|--------------------------|--------------------------|--|
| Past | Current | |
| <input type="checkbox"/> | <input type="checkbox"/> | doesn't imitate waving "bye-bye" or "patty cake" etc. (physical imitation) |
| <input type="checkbox"/> | <input type="checkbox"/> | doesn't repeat words/things said to him |
| <input type="checkbox"/> | <input type="checkbox"/> | doesn't repeat words generally, but usually did what he was asked to do |

Response to Sounds, Speech

- | | | | | | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---|
| Past | Current | | Past | Current | |
| <input type="checkbox"/> | <input type="checkbox"/> | often ignores sounds | <input type="checkbox"/> | <input type="checkbox"/> | often ignores what is said to him/her |
| <input type="checkbox"/> | <input type="checkbox"/> | afraid of certain sounds | <input type="checkbox"/> | <input type="checkbox"/> | really likes certain sounds (music, motors, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | seems to hear distant or soft sounds that most other people don't hear or notice | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | unpredictable response to sounds (sometimes reacts, sometimes doesn't) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | responds to speech and sounds like other children of the same age | | | |

Visual Response

- | | | | | | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|---|
| Past | Current | | Past | Current | |
| <input type="checkbox"/> | <input type="checkbox"/> | stares vacantly around room | <input type="checkbox"/> | <input type="checkbox"/> | plays with turning lights on and off |
| <input type="checkbox"/> | <input type="checkbox"/> | often doesn't look at things | <input type="checkbox"/> | <input type="checkbox"/> | distracted by lights – stares at certain lights |
| <input type="checkbox"/> | <input type="checkbox"/> | likes to look at self in mirror | <input type="checkbox"/> | <input type="checkbox"/> | very interested in small parts of an object |
| <input type="checkbox"/> | <input type="checkbox"/> | likes to look at shiny objects | <input type="checkbox"/> | <input type="checkbox"/> | looks at things out of the corners of eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | stares at parts of his/her body (e.g. hands) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | often avoids looking at people when they are talking to him | | | |

Other Senses

- | | | | | | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| Past | Current | | Past | Current | |
| <input type="checkbox"/> | <input type="checkbox"/> | puts many objects in mouth | <input type="checkbox"/> | <input type="checkbox"/> | likes vibrations |
| <input type="checkbox"/> | <input type="checkbox"/> | licks objects | <input type="checkbox"/> | <input type="checkbox"/> | doesn't notice pain as much as most people |
| <input type="checkbox"/> | <input type="checkbox"/> | overreacts to pain | <input type="checkbox"/> | <input type="checkbox"/> | smells objects unusual or unfamiliar objects |
| <input type="checkbox"/> | <input type="checkbox"/> | chews or eats objects that are not supposed to be eaten | | | |

Emotional Responses

Past	Current		Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	temper tantrums	<input type="checkbox"/>	<input type="checkbox"/>	laughs/smiles for no obvious reason
<input type="checkbox"/>	<input type="checkbox"/>	overly responds to situations	<input type="checkbox"/>	<input type="checkbox"/>	moods change quickly/for no apparent reason
<input type="checkbox"/>	<input type="checkbox"/>	cries/seems sad for no obvious reason	<input type="checkbox"/>	<input type="checkbox"/>	often has blank expression on face
<input type="checkbox"/>	<input type="checkbox"/>	little response to what is happening around him/her			

Name child's positive attributes:

1. _____
2. _____
3. _____
4. _____

FAMILY MEDICAL/PSYCHIATRIC HISTORY

Have any members of the biological mother's or biological father's families had any of the following problems or disorders (check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Birth Defect | <input type="checkbox"/> Chromosomal/genetic disorder | <input type="checkbox"/> Obsessive Compulsive Disorder |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Severe head injury | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Physical handicap | <input type="checkbox"/> Nervousness/Anxiety | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Tuberos Sclerosis | <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Huntington's chorea | <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Sickle-cell anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Food allergies |
| <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Depression | <input type="checkbox"/> Physical/Sexual abuse |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Speech/language delay |
| <input type="checkbox"/> Autism/PDD | <input type="checkbox"/> Reading problem | <input type="checkbox"/> Other learning disability |
| <input type="checkbox"/> Emotional disturbance/mental illness | | <input type="checkbox"/> Bipolar/manic-depressive disorder |
| <input type="checkbox"/> Tics/Tourette's syndrome | | <input type="checkbox"/> Antisocial Behavior(assaults, thefts, arrests) |
| <input type="checkbox"/> Childhood behavior disorder (aggressive/defiant/ADHD) | | |
| <input type="checkbox"/> Other: _____ | | |

Has anyone in the family ever received special education services? No Yes - for what reason?

Family Changes and Stressors: Please indicate any major family stresses the family and/or child is currently experiencing or has experienced within the last year.

- | | | |
|--|--|--|
| <input type="checkbox"/> Marital discord/fighting | <input type="checkbox"/> Separation | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> Birth/Adoption of another child | <input type="checkbox"/> Sibling conflict | <input type="checkbox"/> Parent-Child conflict |
| <input type="checkbox"/> Custody disagreement | <input type="checkbox"/> Single-parent family | <input type="checkbox"/> Parent/sibling death |
| <input type="checkbox"/> Parent deployed extensively | <input type="checkbox"/> Parent emotionally/mentally ill | |
| <input type="checkbox"/> Involved in juvenile court | <input type="checkbox"/> Abandonment by parent | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Parent substance abuse | <input type="checkbox"/> Child Neglect | <input type="checkbox"/> Physical abuse |
| <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Parental disagreement about child-rearing | |
| <input type="checkbox"/> Involved with Social Services/Child Protective Services | | |
| <input type="checkbox"/> Other, if not listed: _____ | | |

SCHOOL HISTORY

(If more space is necessary, please attach additional sheets or write on the back of this page.)

Current school: _____ School district: _____

Grade level: _____

Type of class: Regular Ed Special Ed Resource ED Behavioral unit

Current # of: Students ____ Teachers ____ Aides ____ Does your child have a 1:1 Aide? _____

Has your child had special education testing in school?

Psychological/Cognitive – Date: _____ Academic – Date: _____

Speech/Language – Date: _____ Other: _____ Date: _____

Is your child receiving any special education services at school? Yes No

Is your child on an IEP (Individual Education Plan)? ____ For what reason? _____

Please list all of the schools, including preschools, your child has attended:

Name of school	Age/grade attended	Hours per day	Days per week

SERVICES - Please list services your child has received.

(Please bring copies of your most recent Individual Education Plan (IEP))

Child’s age when school services began: _____

Individual Education Plan (IEP) eligibility: _____

Which services is your child CURRENTLY receiving through the SCHOOL DISTRICT?

Speech therapy Occupational therapy Physical therapy

Adaptive Physical Education Discrete Trial Training (DTT/ABA) Social Skills

Other - describe: _____

Early Childhood Intervention (ECI): (Please bring copies of your most recent ECI, Individual Family Service Plan (IFSP), and relevant reports to your appointment.)

Is your child currently a client of ECI? Yes No (skip to Private Services)

Which ECI Center: _____ Eligibility category: _____

Child’s age when ECI services began: _____

Which services is your child CURRENTLY receiving through the REGIONAL CENTER?

Speech therapy Occupational therapy Physical therapy

Adaptive Physical Education Discrete Trial Training (DTT/ABA) Social Skills

Other - describe: _____

Private Services (Please bring copies of relevant reports to your first appointment.)

Are you or your insurance company currently paying for services to address your child’s needs? Yes No

Speech therapy Provided by: _____ Age when began: _____

Occupational therapy Provided by: _____ Age when began: _____

Physical therapy Provided by: _____ Age when began: _____

Adaptive Physical Education Provided by: _____ Age when began: _____

Social Skills Provided by: _____ Age when began: _____

Discrete Trial Training(DTT/ABA) Provided by: _____ Age when began: _____

Other - describe: _____